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CONTENTS

PAGE

Eczema in Infancy and Childhood 1–5
William Ewing Sinclair, M.D., Orlando.

An Analysis of Fifty Cases Showing a Basal Metabolism Rate Under 15% Below Average Normal ... 5–8
E. W. Bitzer, M. D., Tampa.

The Present-Day Outbreak of Smallpox 9–11
J. M. Lowrey, M.D., Miami.

Myxedema 11–14
J. W. Snyder, M.D., Miami.

Post-Operative Massive Collapse of the Lung: Report of a Case 14–17
J. A. Beals, M.D., Jacksonville.

PAGE

State Board of Health Notes 17

Foreign Bodies in the Food and Air Passages 17–22
William Jerome Knauer, M.D., Jacksonville.

Editorials: (1) The Kolmer Test; (2) The Gorgas Memorial 23–25

State News Items 26

Schedule of Meetings—Component Societies Florida Medical Association 27

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ECZEMA IN INFANCY AND CHILDHOOD*

WILLIAM EWING SINCLAIR, M.D.,
Orlando.

This is one of the most trying conditions with which the physician has to contend; one in which encouragement is followed by discouragement to parents and physicians alike, to say nothing of the intolerable suffering on the part of the child itself with the possibility of a fatal termination. By so many it is regarded as a local skin affection and unsatisfactory, at its best, to treat. A jar of ointment, with instructions to smear it on the affected parts, occasionally relieves one's mind and accounts for a good many of the failures and discouraging cases that we see. A great deal can be accomplished by an intelligent understanding of the processes at fault and a rational method of treatment instituted, paying attention to all details. The little patient can be spared days of torment and the dread and disappointment of the mother in being unable to exhibit her offspring as the clear, smooth-skinned baby she had hoped for, can be, to a large degree, alleviated.

Children suffering from eczema in any of its forms, or exudative diathesis children, are abnormal. This is noticed in their lowered resistance to respiratory and gastro-intestinal infections, pneumonia and acute ileocolitis not being an uncommon complication and frequently terminating in death, with the peculiar phenomenon that at the height of their illness the eczema clears up. Sudden death in these children is not uncommon, and at autopsy a condition of status lymphaticus is frequently found. There is a marked susceptibility to skin infections, furunculosis often accompanying the eczema. Asthma and chronic bronchitis in the later years of childhood are thought to be closely associated with the condition of infantile eczema, a history of the latter often being obtained. A good many of the cases seen are of the milder type, but it must not be forgotten that with extensive skin involvement in the more severe types, fever, delirium and a fatal termination, due to the profound toxæmia, may result.

The causes of eczema may be divided into (1) External and (2) Internal.

External Causes: Due to the peculiar sensitiveness of their cutaneous vaso-motor mechanism, the skin of these children is readily affected by exposure to light, to wind and to climatic influences or to any source of irritation such as pediculi, scabies, ringworm, hard water, soap, irritation from furs or woolen clothing, acid vomitus, urine, fæces or perspiration. Any one of these conditions may be sufficient to cause the original eczema or an exacerbation of the condition.

Internal Causes: The metabolism of eczematous children shows no characteristic deviation from that of normal children, yet certain facts have been ascertained which throw some light on the question. The food element chiefly at fault is thought to be the fat. Some authorities maintain that it is not directly due to the fat, but to the combination of the fats and sugars in an overfed child. Aschenheim has shown in these cases that the limit of assimilation of sugars is low in a diet rich in corbohydrates and that a condition of alimentary glycosuria results. The general feeling is that it is a combination of all the food elements, in a child greatly over-fed, as improvement frequently occurs when the diet is cut down to one-half, or less, of the total amount previously given in twenty-four hours. Schloss and Balckfann and others have shown by cutaneous tests a susceptibility to animal and vegetable proteins on the part of eczematous children. The chief offending proteins being: Lactalbumin, casein, egg white, whole milk, breast milk, potato, beef, wheat, barley and orange juice. Efforts are now being made to class eczema as an allergic disease. So far, the results obtained by the removal of the offending articles of diet, as demonstrated by the scratch or intradermal methods, have not been as gratifying as anticipated. Occasionally, however, spectacular results follow.

TYPES

The most frequent types of eczema encountered in infants and children are:

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

(1) *The wet type or weeping eczema.* This is usually seen in fat, well-nourished, breast-fed babies in which the mother has an abundance of milk and the child is grossly over-fed, probably on a two or three-hour interval, or allowed to nurse whenever it is restless or crying, with the result that a condition of dyspepsia is inevitable and evidenced by symptoms of colic, irritability, loose, frothy stools and a good deal of gas. The lesions begin as acutely inflamed papules, which coalesce and exude serum and are usually seen on the cheeks, forehead and behind the ears, but maybe on the trunk in the papilliteal and antecubital spaces. The child scratches the markedly irritable and itching surfaces and in a few days the face is covered with a dirty crust of dried blood and serum, and presents a most distressing appearance.

Treatment of this type of eczema is most favorable. The gastro-intestinal symptoms must be remedied by checking vomiting, diarrhœa or relieving constipation, and the total intake of food must be cut down to two-thirds or one-half of original consumption. The child should be put on four-hour intervals of feeding and the feeding time shortened, the amount taken recorded by weighing before and after each nursing. If loose, foamy stools are present, one-half to one ounce of protein milk should be given before each breast nursing. Constipation is best corrected by milk of magnesia, one to two teaspoonfuls each night before last feeding. Care must be taken that the mother's breasts are emptied after each nursing to avoid her milk becoming exhausted. As the eczema clears up, the amount of food may cautiously be increased by lengthening the nursing period, not by shortening the intervals of feeding. The urine should be rendered alkaline by giving soda bicarb. or Pot. citrate.

Local applications are of great benefit in this type of eczema, and crude coal tar is almost specific. This is entirely different from the wood tar of the pharmacopœia and is a by-product in the manufacture of coal gas and may be obtained direct from the gas works or larger drug houses. It is a thick, inky-black substance and should be free from granules.

Most of these eczemas, when seen by the physician, are in the dirty, encrusted stage, and it is first necessary to remove the crusts. This is best accomplished by covering affected areas with soft, sterile lint soaked in olive oil or sweet oil. Place over this a layer of oiled silk and cover face with a mask of fairly heavy muslin in which eye, nose and mouth holes are cut and ends made to tie snugly. After twelve to twenty-four hours the crusts are softened and can be removed with blunt thumb forceps or a probe, wound with cotton.

The crude coal tar is now applied with a wooden tongue blade to the affected areas which are now beefy red and oozing. Strips of soft, sterile lint are laid over this and the face mask adjusted over all. Applications should be made twice a day for three or four days, never attempting to clean off the tar. After this length of time the mask and strips of lint are removed and the tar allowed to wear off. The skin is red and smooth after this process, showing no signs of eczema or of scarring and should be protected by a bland ointment or cold cream.

The following bland ointment is useful:

Zinc oxide	℥iii
Anhydrous lanolin	℥ii
Olive oil	℥ii
Aquæ calcis	℥iii

This should be applied before child goes out of doors and the face protected as much as possible from sun and wind. For two or three weeks no water should come in contact with face. Cleansing can be accomplished with olive oil or cold cream. At the end of this time, bran or oatmeal water and a super-fatted lanolin soap may be used cautiously. An important part of the treatment of any eczema is the prevention of scratching, and to overcome this the arms must be splinted in some manner. Pasteboard tubes are very satisfactory and cause little inconvenience to the child. If much sleep is being lost, bromides or Dover's powders may be given.

(2) *Dry acutely inflamed.* This is seen in the under-nourished child which probably at one time was the fat, over-fed baby brought up on an artificial formula in which the fat and sugar were in excess. Due to dietetic errors, loss of sleep from constant irritation of the eczema, and the general undermining of its health, its nutrition is seriously impaired, which condition must be coped with. The lesions may be on face, body or extremities. In the *mild cases,* a diet of skimmed milk, in which the extra calories required are made up by the addition of farinaceous foods, as barley flour, cream of wheat, granum or the courser cereals in older children,

is suggested. This diet is deficient in the antiscorbutic and antirachitic vitamines, which may be supplied in the form of orange juice (providing the infant does not react in an increase of eczema); if so, tomato juice or vegetable water may be given. The antirachitic vitamine is supplied by giving cod liver oil, which, although a fat, apparently does not aggravate the condition. In the *more severe cases*, they will do better if taken off plain cow's milk and put on a good brand of evaporated milk, remembering that it is 2½ times the strength of cow's milk and must be diluted accordingly. The extra calories required in the diet are made up of farinaceous foods, as before mentioned, and soda bicarb. or Pot. citrate administered. The accessory food factors are supplied as before.

Local treatment differs somewhat in these cases. For them, also, coal tar is efficacious, but should be used in the form of an ointment consisting of:

Crude coal tar 3ii
Zinc oxide
Pulv. amyli aa 3ii
Vaseline ad 3ii

This is a thick, dirty green paste and should be applied with a wooden tongue blade over which is laid strips of soft, sterile lint, and in case of the face, a mask applied. On body and extremities, bandages can be arranged. It is applied two or three times daily until healing occurs, when it is allowed to wear off. It must always be remembered that tar contains a certain amount of phenol and it is wise to go cautiously with an eczema covering a large skin surface.

Another type of this dry eczema seen in children is not acutely inflamed, and this condition responds nicely to applications of bismuth paste, lanolin or first-mentioned bland ointment. If there is some induration of the skin, 10 grs. of salicylic acid may be added to the ounce of paste or ointment. Occasionally, small doses of thyroid extract is felt to benefit this dry, non-inflamed type.

(3) *Seborrhoeic Eczema.* This is usually seen in young infants and is known as the milk crust or cradle cap, when the entire scalp is covered with its dirty, yellow, greasy scales and crusts. In some European countries it is considered a sign of good omen to the child and under no circumstances will it be removed, even though it presents a most disgusting sight. As a rule, it is easily coped with in the early stage, and by anointing the scalp each night with olive oil or vaseline, over which strips of soft lint are placed and a bonnet over all, the scales can be combed off in the morning with a fine-toothed comb, and an ointment of 3% resorcin rubbed in well. Once or twice a week a shampoo with green soap may be given.

In the more severe cases, where the entire scalp is covered with crusts, they must first be removed by applying a boric acid and starch poultice—1 teaspoon boracic acid to every 5 teaspoons starch. It is left on over night, and when peeled off in the morning, the scales come away in the poultice and the scalp is left clean but raw looking. A bland ointment may be necessary for a day or so before commencing the 3% resorcin ointment.

(4) *Intertrigo.* This is found in two types of babies. First, the very fat infant with deep furrows in skin about the genitalia, inner surfaces of thighs, axillæ, folds of neck, front and back, and behind ears. It is due to moisture and friction of opposing skin surfaces, to acid vomitus in the creases of neck or to acid urine or fæces. It is quite easily cleared up by keeping opposed surfaces dry by frequent applications of dusting powders and by separating them with pledgets of absorbent cotton. If about the genitals and thighs and caused by acid urine and fæces, soda bicarb. or Pot. citrate should be given each day to render the urine alkaline and measures taken to check the diarrhœa. The parts should be kept clean with wipes of absorbent cotton saturated in olive oil, and in severe cases the tar ointment applied two or three times daily. The milder cases respond to frequent dusting with any good dusting powder, no diapers to be worn, but a pad of absorbent cotton placed under child to absorb urine and fæces, and the skin exposed to the warm, dry air of the room or direct rays of the sun. The diet of these fat babies should be cut down.

In the second type of baby a condition of marasmus exists; he is a difficult feeding case and is extremely malnourished. It is not uncommon to find thrush accompanying the intertrigo in these cases. The intertrigo may go on in this type of child to a general dermatosis or desquamative erythrodermia, in which the mortality is high. The moderate case responds nicely to tar ointment, and as the general condition of the child improves by proper feedings, so

does the intertrigo. Alkalization is indicated as before.

(5) *Infected Eczemas.* This is seen in malnourished infants chiefly on the scalp, and a generalized condition of furunculosis exists; it is necessary to open all pustules, apply alcohol compresses until the scalp is clean and then a 10% ammon. mercurial ointment. Mixed staphylococcus vaccines are felt to hasten recovery in some cases and are worth resorting to.

A few general remarks on the treatment of all eczemas may not be amiss.

1. No water of any description should be used in the facial type until all eczematous lesions have disappeared. Cleaning with olive oil and absorbent cotton may be resorted to. On the body, after eczema has cleared up, one or two baths per week may be permitted, with oatmeal or bran water, using a super-fatted lanolin soap.

2. No wool or fur should be next the infant's skin, and particular care should be taken that the child does not scratch himself, thereby undoing in a moment what has taken days to accomplish.

3. Attention to every detail is necessary, as one patient may present several forms of eczema, each of which will require different treatment.

4. Correction of dietetic errors is just as important as local treatment, if not more so.

5. Until we are sure of our ground, the skin should be protected at all times from sun or wind and climatic changes by the application of cold cream or a bland ointment.

6. So long as you are getting results from a chosen course of treatment, stick to it.

DISCUSSION

Dr. N. L. Spengler, Tampa:

Dr. Sinclair certainly has presented for our consideration a most important subject in the diseases of children.

The beginning of what I will have to say will be a consideration of the prophylactic handling or treatment of children in eczematous conditions. A child's skin is very delicate, very tender, and very susceptible to all kinds of irritations, either from the air or from powders or from clothing, or even a draught from a window. I feel that a great many of the eczemas in children, especially the facial types, could be eliminated by prophylaxis. Now, a great many times I think eczema is caused by the use of strong alkaline soaps used too frequently on these children. If we would use olive oil, which is very mild, or a non-irritating, bland ointment, on these children from time to time, even up to a year old, I think we would preserve the skin in its original state and keep the unity and resistance, that in later life we would not have so many children with eczematous conditions of the face. Now, in bathing a child with strong alkaline soap, we find that nearly always there is an accumulation of the soap in the superfolds of the groin, around the buttocks and scrotum, and especially around the face and eyes, and our eczematous conditions begin there, and later on we get these conditions which we have so much trouble handling.

In regard to the treatment by use of coal tar, I feel that it is about our best remedy, and I think Dr. Sinclair has certainly brought out these things very clearly.

In regard to the food: We have been able to demonstrate almost conclusively that certain foods, when given to these children, produce certain types of eczema, and when these foods are discontinued, the eczema disappears. The child, of course, has to be sensitized to almost every type of food, so the skin test in these studies, I feel, is of very little value. We would hardly have time to carry the skin test out. In the case of a breast-fed child, it seems that the best thing for it is to dilute the mother's milk by giving water, or some diluent, before nursing or after nursing, as we see fit. In the case of a table-fed child, select the right food, or combination of foods, and handle them that way.

Dr. J. D. Love, Jacksonville:

I thoroughly agree with both Dr. Sinclair and Dr. Spengler as to the futility of the skin test in determining the cause of eczema. That has yet to be proven.

As far as the breast-fed child is concerned, we practically never see a case of eczema, except in the case of a child that is being over-fed. It is the large, obese child, in most cases, that is suffering with eczema. I doubt very much if any one or more of the fat elements play any important part in the production of this. That still remains to be proven.

In the treatment of these eczemas of the breast-fed, probably the most efficacious measure is extending the interval between feeding and

cutting down of the fluid intake, at the same time strengthening the skin by cleansing it with either olive oil or liquid albumin. As a matter of fact, it is my opinion that there is only one form of dry eczema in childhood, and that is the so-called exudative diathesis of children.

We also have an eczema that is presumably caused by hyperthyroidism, which is closely related to the diathesis of children. Most of the so-called cases of exudative diathesis are simply that of dermatitis, caused by some local irritant. You can almost always diagnose a case of eczema due to hyperthyroidism from the fact that it exists mainly about the neck and chest, and is accompanied by certain cracking of the skin of the hands and palms. We have no real eczema of hands or feet. The so-called eczemas of this portion are due to the fungus and responds to almost any rational form of treatment. The so-called papular form of eczema about the feet and hands is either due to a luetic condition or scabies.

I would emphasize the warning of Dr. Sinclair and Dr. Spengler concerning the extensive use of tar ointments. It is a very good general rule to follow not to apply tar ointment to more than one-fourth of the body at a time. Eczema in a baby resembles somewhat the vomiting of pregnancy—what would heal a case this month would have practically no effect on a case two or three months after that. Practically anything will cure certain cases of eczema and almost everything will fail in other cases.

Dr. Clifton Moor, Tallahassee:

There is only one point that I want to mention, particularly, and that is I think the use of tar ointment, of course, is a general routine, but in my experience I have found that tar ointment cannot be prescribed without a good deal of detail unless your druggist has been sufficiently instructed beforehand. Another thing, it has been the case in a good many instances that tar ointment used continuously, even for several days, produces an irritation of the skin in itself. I have made it a rule to order tar ointment specifying crude coal tar, and give detailed instructions to the druggist about it—in addition to that instructing the mother that the ointment is to be applied twice in twenty-four hours, and at the end of twenty-four hours the old ointment is to be carefully removed with olive oil, and begun again. In other words, none of the old ointment stays on longer than twenty-four hours. I believe, that we find certain irritations from the old ointment itself, which is probably due to oxidation of the ointment after smearing it on the surface. Crude coal tar is a rather unique combination. None of us knows just what is in it, or how much is in it, and for that reason I think that precaution is especially necessary that the ointment shall be removed thoroughly with sweet oil after it has been on for twenty-four hours.

CONCLUSION

Dr. W. E. Sinclair, Orlando:

I have not much to say, in closing, except to emphasize the point Dr. Spengler brought out, that prophylaxis plays an important part in the prevention and treatment of eczematous conditions in children.

Also, I want to mention, that in these cases of glandular dysfunction, particularly the thyroid, I feel, as Dr. Love, although not absolutely sure, that we have had remarkable results in giving small doses of thyroid extract in these dry, non-inflamed types of eczema. It has been the writer's habit to give 1/50 gr. of thyroid extract twice a day.

In reply to Dr. Moor: He feels that tar ointment will irritate the skin in some of these eczematous cases. My experience has been this, and I tried to emphasize it in my paper, that these tar ointments should not be removed. I feel, probably, that some of the irritation of the skin which he tells you about may be caused by the fact that he tries to remove the tar ointment, which is rather a difficult task. It is the writer's belief that by leaving this tar ointment on, you prevent irritation of the skin.

AN ANALYSIS OF FIFTY CASES SHOWING A BASAL METABOLISM RATE UNDER 15% BELOW AVERAGE NORMAL*

E. W. Bitzer, M.D.
Tampa.

The clinical use of basal metabolism determinations was for a time largely confined to cases showing evidence of exophthalmic goiter or toxic adenomas. Gradually, however, interest has

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

been centered on the study of hypothyroid states and other conditions showing low basal metabolism readings. Severe cases of myxedema were readily detected, but it is only recently that much attention has been paid to the milder thyroid deficiencies and the early myxedemas.

The object of this study is to point out some of the most characteristic symptoms and their probable relation to thyroid deficiency, and the relation of low metabolic rates to other clinical states. The fifty cases presented are mostly office cases in private practice, and mild thyroid deficiencies or early myxedemas. All basal metabolism determinations were done at the Bayside Hospital Laboratory under the direction of Dr. Herbert R. Mills.

This group of cases was selected from 403 patients who had basal metabolism determinations. Of these cases, 176 were between 9% below and 10% above average normal, 71 were higher than 10% above, and 156 were 10% below normal and lower. The total number 20% below and lower was 37.

Of the fifty cases selected, 15% under normal and below, two were between 10 and 19 years of age, two were between 20 and 29 years, sixteen were between 30 and 39 years, twenty-two were between 40 and 49 years, five were between 50 and 59 years, and three were between 60 and 70 years. There were seventeen males and thirty-three females. Only two cases occurred in individuals leading active physical lives. No relation to occupation was noted other than a disposition to occur in sedentary occupations.

The chief complaint of these cases was quite varied, as many had associated conditions and, usually, the chief complaint was that of the associated disease, and other symptoms were only elicited by questioning. Not one of the fifty cases complained of difficulty in keeping warm in cold weather, but on questioning many admitted this disability, and some suffered severely. The symptom most frequently encountered was fatigability. Forty-five of fifty cases presented this symptom, and a few to a marked degree. Thirty-two had difficulty in keeping warm in cold weather. Thirty-seven complained of constipation. Thirty-one had various types of digestive disturbances other than constipation. Sixteen complained of disturbances of breathing or shortness of breath. Frequent colds occurred in ten cases, and five complained of dry skin. General aching was an inconstant symptom, that occurred in a marked degree in only two cases. Pain or a tired feeling in the back in the scapular region was a frequent complaint. Loss of sexual power occurred in one case. The menopause occurred in one at 38 years, in two at 40, and two at 42 years. Irregular menstruation was present in three cases. Six cases complained of mental deterioration and loss of memory. In five cases, headaches were a prominent symptom. Mental depression was a marked feature in one case.

Physical examination disclosed normal weights in thirty-nine cases. Eight were under and three were above normal weight. Twenty-two ran definitely subnormal temperatures. Twenty-eight showed respirations under twenty per minute, and seven a pulse rate below seventy per minute. Three cases had systolic blood pressures under 100, six between 100-109, ten between 110-119, nineteen between 120-129, four between 130-139, six between 140-149, and two above 150. In one case the pulse pressure was under twenty, in six between 20 and 24, in thirty-one between 25 and 29, and in twelve above 40. The basal metabolism rate in thirteen cases was between 16 and 19% below average normal, in thirty-two cases between 20 and 29% below, and in five cases between 30 and 36% below. The knee jerks were decreased in four, increased in four, and normal in forty-two cases. Changes in the hair, temporal thinning, thinning of the temporal half of the eyebrows, loss of hair on the trunk and in the axilla, and coarse hair, were noted in ten cases. Definite evidence of myxedematous swelling of the skin was found in fourteen cases. A secondary anemia was present in eight cases. Ventricular premature beats were found in five cases. Electrocardiograms were only done on a few of these cases, but in one instance, a negative T, in the absence of other evidence of cardiac disease, raised the question of thyroid deficiency. Enlargement of the thyroid gland was found in one case, a well-marked irregular nodular goitre. In one instance thyroid deficiency followed removal of the gland. None of these cases showed evidence of a myxedema heart.

From an etiological point of view, there are six possible classes of cases, functional, congenital, surgical, or following X-ray treatments, thyroiditis or other insults to the gland, the menopause, and iodine deficiency.

There is no doubt that the depressive emo-

tional states are often followed by thyroid deficiency, and occasionally the opposite effect, exophthalmic goiter. Excessive mental work, worry, and responsibility are the most prominent factors in the etiology of functional thyroid deficiencies. Marked loss in weight results in a definite lowering of the metabolic rate, but is usually very temporary unless associated with some functional nervous disturbance. It seems probable that residence in a hot climate has a tendency to accentuate functional thyroid deficiency through lack of stimulus for heat production or through the heat regulatory mechanism in its efforts to maintain a normal temperature where the temperature of the air is near that of the body.

There are congenital deficiencies as well as absence of the thyroid, and it is probable that some of the functional cases are based on a mild congenital deficiency.

Thyroiditis is probably undiagnosed in the vast majority of instances, and is frequently followed by a deficiency of secretion.

The association of myxedema with the fourth decade and the female, has led to the assumption that it may bear a relation to the menopause. Of the seventeen males in this series, one was between 10 and 19 years of age, one between 20 and 29, five between 30 and 39, eight between 40 and 49, and two between 50 and 59. This shows a greater incidence in males than in the females in the fourth decade, and it is probable that the menopause bears no relation other than an accidental one.

It seems improbable that iodine deficiency is responsible in any way for thyroid deficiency.

Of associated conditions, the chronic infections were most frequently encountered. Most prominent in this list were infected teeth, tonsils, and antra, chronic cholecystitis and chronic appendicitis. Chronic infections of this class were found in nine cases. Neuroses or psychoneuroses were present in eight cases. Chronic arthritis occurred in four cases, chronic colitis in two cases, chronic nephritis in one, hay-fever and food allergy in one, and epileptiform attacks in one. Definite evidence of other endocrine disturbances, other than the gonads were noted in one case. This case showed an erosion of the posterior clinoids with very slight evidence of acromegaly. The subsequent history of this case suggests that there is little, if any, evidence of pituitary disturbance at this time and that myxedema is the chief cause of her disability. One case showed vitiligo of the hands which is suggestive of pituitary disturbance (Englebach, Milliam, Studies on Growth and Pigmentation, Med. Clin. of N. A., Vol. 9, No. 1, p. 1, July, 1925), but no other evidence was discovered.

It is quite evident that both chronic infections and functional nervous disturbances play some part in the production of hypothyroidism.

The treatment of hypothyroidism is not as simple as it would seem. It is impossible to calculate the proper dosage from the basal metabolism rate. The only successful method is by checking the dosage with basal metabolism determinations. There is no question but that certain individuals are able to attain basal conditions with greater ease than others, and this of necessity is certain to affect the findings, and is a situation the effect of which cannot even be estimated. There are a host of accidental influences that may cause a variation in the reading. The first test is notoriously apt to be misleading. We have repeatedly observed a rate of from 5 to 10% below that of the initial rate, following thyroid medication. From this it is readily seen that each case must have several basal metabolism determinations before the dosage can be fixed with a reasonable degree of accuracy. In addition to this, certain cases show a variation at times in the amount of thyroid necessary to produce a normal basal metabolism rate.

We have observed no ill effect from the administration of thyroid that was in any sense serious, or other than temporary. In a few cases, the basal metabolism was elevated sufficiently to produce symptoms, but these rapidly disappeared as soon as the dosage was reduced. In one case that was ultimately relieved of all symptoms, a fairly large initial dose of thyroid precipitated severe aching in the extremities, back and head, lasting about one week. It is probable that this can be largely eliminated by a gradual increase in the dose.

The maximum dosage in this series was six grains of desiccated thyroid daily. Twenty-five showed definite improvement under thyroid medication. Five were cured. One case was not treated with thyroid. Three that were treated showed no improvement. In the remaining cases, it was impossible to definitely determine the amount of improvement due to thyroid medication, if any. It is of interest to note that, in one myxedema case, frequent ventricular premature

beats were stopped by thyroid treatment and in two cases severe constipation was relieved.

SUMMARY.

The chief symptoms that should lead one to suspect hypothyroidism are fatigability and difficulty in keeping warm.

Myxedema is difficult to detect on physical examination except in the late stages.

The association of low metabolisms with chronic infections, functional nervous diseases, and states of under-nutrition are noted.

There are a certain number of low metabolism cases that show no improvement on thyroid medication.

Credit is due Miss Noxon for valuable assistance in the preparation of this paper.

DISCUSSION

Dr. T. Z. Cason, Jacksonville:

I was very glad to hear Dr. Bitzer's paper. I think that it is a subject that the general man should know a great deal of.

For the past five years we have been doing basal metabolisms on cases where it is indicated at Riverside Hospital both in the hospital and out-patient departments. I did not read any of Dr. Bitzer's paper, and of course most of it is entirely new to me, so I am not making comparisons, but my own observations. I have noticed in a number of cases of persistent colds that their basal metabolisms were low. I have one distinct case that had been worked out in several places, but strange to say a metabolism had never been done, although this particular patient had been seen by several Neurologists—none in Jacksonville and none in the State of Florida, we are all innocent—and a metabolism had not been done. This case showed a distinctly low metabolism rate, and as long as we are able to keep her metabolism anywhere near normal we can keep off her seizures. The difficulty I have found is in regulating her dose, because even a small dose will produce symptoms, as Dr. Bitzer is apparently fully aware, and a not sufficiently large dose will do no good. So it has been a real problem in our particular case to get her into the proper dosage.

We have one interesting case that came under our observation about two years ago with rheumatism. She was worked out and no foci of infection was found, but we found a low metabolism rate, which was later worked out in Louisville and Knoxville, Ky., with the same findings. Some one, not myself, had intelligence enough to give her thyroid extract. As soon as her metabolism approached normal her rheumatism entirely disappeared. It has become so marked with her that she knows by the way her rheumatism behaves just how her metabolism is getting along. This is the most marked case we have seen.

One point Dr. Bitzer brought out, we have observed very carefully and it has been of considerable value. He mentioned the subject of low blood pressure and gave you his statistics. Not all low metabolisms have low blood pressure as he indicated, but over a period now of three years since we have been observing this carefully every case with a markedly low blood pressure has had a low metabolism, with one or two striking exceptions—and the administration of thyroid extract has brought their blood pressure up. They also had most of the other symptoms, the cardinal symptoms that Dr. Bitzer has mentioned.

We have observed a few cases as he mentioned with enlarged thyroid gland and low metabolisms. One of these cases, despite the low metabolism test, developed marked cardiac symptoms. She was operated on with excellent results.

I think the question of thyroiditis is not closely enough observed—we are not giving enough attention to that question along with our low metabolisms, and I am certain that not enough metabolisms are being done.

CONCLUSION

Dr. E. W. Bitzer, Tampa:

Finally, I should like to call attention to one thing that has become apparent from these cases that are being observed over a long period of time, and that is the fact that they present somewhat the same peculiarities as our diabetic cases, particularly the ones that we give insulin to. It would seem to me, in a certain number of them, that the basal metabolism goes below normal, showing a progressive tendency to become worse. If they are given thyroid very often after a certain length of time, we have to discontinue the thyroid, and they may remain normal for a considerable length of time.

Perhaps more will come to light in connection with this subject after these cases have been studied for a longer period of time. It is rather an interesting thing, and it is rather startling the results that are sometimes given, although often they are disappointing.

THE PRESENT-DAY OUTBREAK OF SMALLPOX*

J. M. Lowrey, M.D.,
Miami.

Close students of medicine have noted in the literature, for many years, that influenza, typhoid fever, cholera and smallpox recur periodically, usually at intervals of five to seven years. This has been claimed by some to be due to the fact that in the meantime a non-immune population has grown up and is ripe for the harvest. But I do not think this fact is in all cases an adequate explanation. Certainly such an explanation does not suffice for the present excess of smallpox in this city, for there have been only 31 cases among children under fifteen years of age and of these 16 were in children under five years of age. By far the largest number of cases has occurred in adult colored males.

The present outbreak started on December fourth, when a colored adult male was found with smallpox in the third week of its course. He had been driving a delivery wagon around the city since his arrival from southern Georgia some ten days or two weeks before. About a week later a second colored adult male was found with smallpox also well advanced toward recovery. This man had been working on the docks of one of the steamship companies with smallpox in full bloom for the previous ten days. Soon other cases made their appearance and as the city hospital had but about a half dozen cubicles available for the isolation of the disease, and as there were no other facilities available, the cases had to be left in their homes. Of course it was a pitiful farce to try to quarantine a colored male patient with smallpox, who never felt more like going on a jamboree in his life, in, say a negro rooming house with thirty or forty other negro boarders, none of whom cared a whoop whether they contracted the disease or not. Time and again our physicians have almost had to resort to physical force to keep visitors from entering the patients' rooms even after they have been informed of the nature of the disease. Of course, they entered as soon as the doctor turned the corner. Not, however, without having been vaccinated.

It was recognized at once that the answer to the problem lay in the immediate vaccination of the entire colored population and as soon as authority to employ extra physicians could be obtained, search was begun for them.

But owing to the scarcity of doctors in Miami and the consequent great demand for their services, the securing of a sufficient number was no easy matter. It was days before a single man could be secured. Finally, however, by January 19, six extra men had been placed on the work and rapid progress was made. Ultimately nine were secured and they have done a wonderful piece of work under almost unsurmountable difficulties.

In the meantime authority was being sought to provide isolation facilities for the cases we knew were inevitable and about January 28 construction was started on an emergency hospital located on the thirty-five-acre tract belonging to the city and lying west of the incinerator. Six cottages were rapidly erected, one for white males, one for white females, one for colored males and one for colored females, an administration office and a kitchen. These were occupied on February 12. They were intended to accommodate thirty patients each, but the preponderance of colored males was so heavy that all white female patients (of which there have been but few) were placed in Jackson Memorial and two cottages were devoted to colored males.

These cottages are equipped with city water, electric lights and gas, modern flush closets, electrically heated showers, and with lavatories. Each cottage has an isolation room at one end, for emergency use in case of the development of some intercurrent communicable disease. This provision has proved a blessing as both mumps and diphtheria have occurred among those isolated primarily for smallpox, and no secondary infections were noted. A small separate shack was also provided and in this have been placed cases sent in with diagnosis of smallpox, but in which the diagnosis was incorrect. Three cases of chicken pox have been thus received; also one case of secondary lues and one of potassium iodide eruption. These have been segregated and at once vaccinated and held fourteen days. In no case has such a patient contracted smallpox.

While the emergency hospital was being erected vaccinations were being pushed vigorously. There being no compulsory vaccination law, only those who were willing to be vaccinated could be immunized. The newspapers would not publish the facts and consequently the people could not

*Read before the May Meeting of the Dade County Medical Society.

be advised of the existence of the disease nor warned of the necessity of being vaccinated. However, all employees of the executive offices of the city were at once vaccinated, all members of police and fire departments, all employees in street cleaning and construction divisions, all employees of all laundries in the city, all patients in Jackson Memorial Hospital; and prisoners in the city jail have been vaccinated about once each week. Letters were written to all employers of large groups of labor, such as post office, Western Union and Postal Telegraph Companies, telephone company, etc., offering services of our clinic or offering to send doctors to them to immunize their employees.

It was at once recognized that the most common and at the same time most dangerous points of contact between the two races were in restaurants and hotels. Consequently physicians were detailed to call these places on phone and make appointments for vaccination of all their employees. Food handlers applying for examination at the city clinic for permit under State law were required to submit to vaccination. At the same time vaccination of the schools was started. This work could only be done on written consent of parents, so twenty thousand blank requests for signature of parents were distributed to the pupils. A liberal response was received and the white schools are now eighty-one per cent vaccinated and the colored schools one hundred per cent vaccinated—a result that compares very favorably with conditions obtaining in almost any city in the country. It was realized that this work would be educational as well as protective so all men employed, except one exceptionally well qualified senior course student, were graduate physicians and all nurses were graduate, registered nurses. A uniform procedure, the puncture method, was employed and the strictest aseptic precautions were observed. Pupils were advised to use no dressings or shields and in ten days re-examinations were made to enforce this ruling. Many dressings and shields were removed. The results were splendid. No really bad arms and no infections have been noted. The percentage of takes has been very high and the resulting scars usually about the size of the little finger nail.

Immediately after the schools were finished an intensive wholesale vaccination of the colored population was begun. This work was done particularly in the Northwest section, between the railroad on the east, Sixth avenue on the west, Fifth street on the south, and Thirty-sixth street on the north, in Coconut Grove and at the city docks. At first they were taken as the men would come to them on the streets because the largest number could be reached in this way in the shortest time.

On the second covering a house to house canvass was done and all inmates found were vaccinated. It was now found that cases were not only not being reported but were being hidden and many were discovered behind locked doors after breaking open the doors, and patients sent to isolation hospital. On the third covering an actual room-to-room search was made and later further vaccinations were done on streets, wherever unvaccinated people could be found. Truck loads of laborers returning from work were stopped, unloaded, vaccinated and allowed to proceed.

It is impossible to overestimate the value of the police force in this work. The first day of the vaccination of negroes two doctors worked all afternoon in one block and vaccinated seventy-five. The next morning the same two doctors went back to the same block with two officers and vaccinated four hundred and fifty men.

There have been to date 427 cases divided as follows:

Colored male	267
Colored female	68
White male	61
White female	31

There have been no deaths. No hemorrhagic cases and only five confluent cases. The majority have been mild discreet cases of the type described by many authors as alastrim, which is nothing more nor less than mild smallpox.

There have been many instances where all but one member of a family have been vaccinated, this member afterwards contracting the disease. Many instances have occurred where the mother would be absent; the children would be vaccinated but the mother would contract the disease, later taking her infant to the hospital with her where it would remain in the ward for two or three weeks, intimately associated with the disease in all stages, but would not contract smallpox; in others the mother has hidden the child from the vaccinators and it would subsequently contract the disease, the mother accompanying it to the hospital and remaining in the wards in close contact with the disease in all stages, but

escaping—evidence of the efficacy of vaccination that should convince even a Christian Scientist.

Not a single one of the 427 cases that have come to the observation of the Division of Health ever had been successfully vaccinated at any time in their lives and not a case of the disease has been reported in a child of school age since the schools were vaccinated.

Not a case of serious result of vaccination has been brought to the notice of the Division of Health. One case of tetanus was reported in a negro girl fifteen years of age employed in a laundry and vaccinated three weeks previously. The vaccination had run a perfectly normal course and was healed. An open sore was found just above the inner malleolus which was the focus of infection. The patient made a rapid recovery under tetanus antitoxin.

Attention is invited to the great preponderance of males over females in this series of cases, there having been 328 males and only 99 females. This is explained by the fact that all vaccinations practically have been done in the day time, the males during the day hours being absent at work. It has been extremely difficult to reach the male population during working hours.

Vaccinations have been performed on people in all conceivable physical conditions and no attention has been paid to age. Individuals from two days to eighty years old have been vaccinated and without ill result.

One puzzling feature arose during the vaccination. Nothwithstanding the fact that we covered the Northwest section and Coconut Grove on three different occasions, large numbers of unvaccinated people continued to be found. Finally our chief nurse was requested by a doctor at Perrine to bring vaccine points and help her vaccinate one hundred and fifty negro men employed in a canning factory. When they were lined up it was found that of the one hundred and fifty, one hundred and twenty had already been successfully vaccinated on the streets in Miami. It was then realized that at one time or another practically all the negroes in Dade County had been caught on the streets in Miami and vaccinated. In other words, instead of vaccinating the city we were vaccinating the entire county.

The county has taken absolutely no steps to protect the thirty odd thousand people outside the city of Miami and we are daily receiving reports of cases of communicable diseases in the county with absolutely no precautions being taken against spread of disease.

DETAILED REPORT OF CASES SMALLPOX REPORTED FROM DECEMBER 1, 1925, TO APRIL 2, 1926.

Total cases reported, all ages:

White—male	61
White—female	31
White total	92
Black—male	267
Black—female	68
Black total	335
Total cases reported (white and black)	427

Cases reported between ages 5-15:

White—male	3
White—female	4
Total	7
Black—male	3
Black—female	5
Total	8
Total cases reported	15

Cases reported under 5 years of age:

White—male	5
White—female	1
Total	6
Black—male	4
Black—female	6
Total	10
Total cases reported	16

MYXEDEMA*

J. W. SNYDER, M.D.,
Miami.

Boothby defines myxedema as "A constitutional disease, occurring in adults, due to a decrease or absence of the secretion (thyroxin) of the thyroid gland as a result of its atrophy or removal, characterized by a markedly decreased basal metabolic rate, a myxedematous condition of the tissues, a slowed, impaired mental condition, a typical facial expression and other secondary manifestations."

Our knowledge of myxedema dates from 1873,

*Read before the May Meeting of the Dade County Medical Society.

when Sir William Gull described two cases in women, calling attention to the peculiar leather-like skin and mental stupidity. Two years later, Wm. Ord, impressed with the peculiar edema of the skin, found at autopsy, suggested that the name myxedema be given to the disease. Reverdin and Kocher, independently in 1883, described the physical and mental changes undergone by their patients following total thyroidectomy. The relation of this post-operative state to idiopathic myxedema was soon recognized. The Myxedema Commission of the Clinical Society of London in 1888 reported that genuine myxedema, sporadic cretinism, and the cachexia, resulting from total thyroidectomy, were essentially the same condition.

The frequency of occurrence of this condition is undoubtedly much greater than reports would indicate. It is surprising how many frank cases of myxedema are treated for other conditions. Sturgis reports that of ten frank cases previously examined, only one was suspected of having myxedema. It is needless to say that with so characteristic a picture as is presented by this disease, no special difficulty is encountered in diagnosis, if the condition is borne in mind.

The exact etiology of the disease is still uncertain. We know that it follows partial thyroidectomy in rare instances. This is especially true, if post-operative wound infection occurs with further destruction of the remaining gland substance.

In most instances we do not know what causes the thyroid to atrophy and cease functioning. Plummer is of the opinion from a study of 54 cases that in most instances it is the result of previous thyroiditis. In none of the Plummer cases was the thyroid enlarged. At autopsy the thyroid shows mainly atrophy and increase of fibrous tissue.

As the result of the investigations of Plummer and Kendall, we now have available the active product of the thyroid gland in pure form, namely thyroxin. It has been shown that thyroxin is in all probability an active catalysis of oxidative processes in the body. Without its energizing influences the chemical changes in the body lag, and the individual constantly travels at low speed. We know that as small an amount as 14 mg. of thyroxin, if maintained constantly in the body, will restore such a thyroidless individual to normal. We also know that thyroxin wears out at a rate of about 4 mg. per day, and must be replaced.

The onset of myxedema is slow and insidious. Relatives and friends seldom notice any departure from the normal until the changes are pronounced. All activities are slowed, both mental and physical. The face appears coarse and mask-like with wrinkling about the eyes and thickening of the lips and the features in general. The skin over the body is dry, and an elastic, non-pitting edema is present. The hair is dry, the eyelashes and eyebrows may be lost along with the hair of the head. The nails are brittle. Perspiration is decreased or absent. The tongue is large and speech is slow and difficult. Mental processes are slow, but accurate in the main; the general attitude is that of calm indifference, although irritability may be present. Drowsiness and a tendency to drop off to sleep during the day time may be the cause of the patient first seeking medical advice. Muscular action is slow, and incoordination may exist. The gait may be likened to the waddling of a duck. The reflexes are slowed as noted by Chaney. The patient feels cold even in hot weather. Amenorrhea in the female and impotence in the male are common symptoms. Hemorrhage from the mucous membranes is frequent, and a secondary anemia is often pronounced.

Myxedema is usually mistaken for nephritis by reason of the pale edematous skin and the presence of albumen in the urine. The edema, however, is hard, does not pit on pressure, and the wrinkles of the face are accentuated rather than obliterated. The peculiar facies and marked anæmia in some cases have led to the mistaken diagnosis of pernicious anæmia. Other cases, because of aching about the joints and peculiar gait, are treated for chronic arthritis. If the clinical picture of myxedema is held in mind, such mistakes will seldom occur.

Basal metabolic rate determinations are of great help in diagnosis. Most rates are 30 to 40% below the normal, although some cases have rates considerably higher. Plummer lays stress on the development of edema, when the rate passes 18% below normal. A diagnosis of primary myxedema with a rate of —20 and no edema is open to question in his opinion. A shift of a few points in the metabolic rate may cause the edema to appear or disappear in myxedema with a rate ranging near this point. Other clinical states give metabolic rates as low as

these seen in myxedema, but of quite different etiology. They probably represent an adaptation of the thyroid function to the lessened demands of the organism. Starvation as seen in hysterical dysphagia, stricture of the esophagus, cardiospasm, anorexia nervosa, etc., is associated with a lowered metabolism and a correspondingly low reading. Low rates are also encountered in various psychoses, pituitary disease and various ill-defined ovarian and endocrine disturbances. Plummer states that a rate as low as 40% below normal in these conditions is not associated with the edema so characteristic of true myxedema.

The object of treatment is to raise the metabolism to normal and to maintain it at that level. One mg. of thyroxin given intravenously will raise the rate 2.8 points. It is therefore a simple matter to estimate the required dosage if the metabolic rate is known. In practice an intravenous injection of 10 mg. is commonly given and a second dose, when the height of the reaction is attained, usually about the 8th day. By the third week the rate should be normal, and oral administration may be started to maintain it at that point. Oral administration is not as exact as intravenous. Absorption from the gastro-intestinal tract is uncertain and allowance must be made for this. Thyroxin in 1.6 mg. amounts given daily, is usually the correct dosage, although one-half this amount may suffice. Desiccated thyroid may be substituted, but more care will be necessary in regulating the dosage. Boothby states that some preparations of desiccated thyroid contain 1 mg. of thyroxin in each 1 to 2 grains, while others require 15 grains to yield an equivalent amount. The patient should be warned of the rather severe general aching and malaise he will experience, while his rate is being elevated, so that he may not be needlessly alarmed or discouraged.

Within a period of one month two cases of myxedema have been seen, both of whom present some points of variance from the usual.

Case I:

Miss P., age 21; single; negative family history; usual children's diseases.

She was in perfect health to the age of 15 years. At that time she developed enlarged cervical glands for which a tonsillectomy was done. This was followed by nervousness, loss of sleep, tachycardia (rate 145), weight loss of 20 lbs. and prominence of the eyes. Exophthalmic goitre was diagnosed and she received intensive X-ray therapy over the thyroid at weekly intervals for six months.

Following this, she was less nervous and began to put on weight, increasing from 130 to 175 lbs. Her skin became thickened, she talked slowly, she did not perspire and felt cold even in hot weather, she experienced a general feeling of depression.

Her menses ceased for two years, then were scanty at 2-3 months' intervals, finally fairly regular. One year ago she flowed profusely for six weeks and was confined to bed 12 weeks in all as a result.

Her present trouble began three weeks ago, as an excessive flow, which persisted in spite of medication. She was admitted to the Jackson Memorial Hospital in critical condition. Her pulse was imperceptible, heart very rapid, respiration irregular and skin a pale lemon tint. The uterus was immediately packed and a transfusion of 500 cc. of citrated blood given from a matched donor.

The uterine pack was removed in 36 hours, and no secondary bleeding occurred.

A subsequent examination gave the following findings: Patient is a fleshy girl, appearing older than her age, 5 ft. 7 in. tall, weight 155 lbs. The skin is thickened and of a pale lemon color, the face is puffy with thick lips and tongue. The hair is dry and scalp scaling. The eyes are prominent with lagging of lower lids and vertical and lateral nystagmus. Teeth are in fair condition. The thyroid is not palpable, no bruits or thrills are present. Speech and thought are slow. No tremor of hands, no petechiæ over the body, heart and lungs negative. Syst. 90, diast. 70, pulse 110. Abdomen negative. Uterus posterior small in size. Adnexa negative. Reflexes slow.

The urine showed traces of both albumen and sugar. The blood gave 55% hemoglobin, 1,768,000 red and 5,600 white cells.

Differential lymph. 11, large mon. 3, trans. 1, neutrophiles 78, eosinophiles 6, basophiles 1, coagulation time 8 minutes, bleeding time 1 minute, platlet count 200,000; fragility, normal; retraction of clot 15 min. Her convalescence was normal and she was dismissed from the hospital in 12 days.

A basal metabolic rate determination showed that she was 41% below normal.

Thyroxin not being available, she was given 12 gr. of desiccated thyroid daily. This produced

a very rapid change in her appearance together with much general aching over the body. She lost weight rapidly, became mentally alert and seemed normal in every way. After 30 days of medication at 12 gr. the dosage was reduced to 4 gr., which she still maintains.

Two subsequent menstruations have been normal. Examination at the present time shows her skin to be of normal texture, warm and moist, the edema has disappeared, eyes are less prominent. Syst. blood pressure is 122, diast. 80, and her weight is 142 lbs. In short, she presents the picture of a normal young woman.

Comment:

It is interesting in this case to speculate as to the etiology of the condition. At first glance we have a picture of exophthalmic goitre, treated by X-ray therapy with destruction of the thyroid substance as a result of such treatment and the development of myxedema. While it is conceivable that the X-ray may do this, it seems to be rather improbable. If her history is recalled, it will be noted that she had an enlargement of the cervical glands for which a tonsillectomy was done, and this was immediately followed by symptoms of hyper-thyroidism. What seems more probable, is that she had an acute thyroiditis, the enlarged cervical glands being an evidence of this inflammatory process in the thyroid. The hyper-thyroid symptoms were those frequently seen in thyroiditis. We also know that thyroiditis may destroy the thyroid gland, and I believe in this case, we may regard the use of X-ray therapy as a secondary factor in the causation of myxedema.

Case II:

The second case was that of a married woman 49 years of age. Family history was negative, except that one sister living in Michigan had a goitre. Marital history: married 21 years, but no pregnancy. Menses: onset at age of 15 years, regular 28 days type, menopause at age of 35.

She has had noticeable enlargement of the neck for six years. Five years ago she felt below par and was treated for anæmia. In the past 18 months her appearance has changed, she has taken on weight, speech, thought and actions are retarded, the features have coarsened, hair has become dry, she has little perspiration and feels cold, even in warm weather. Her speech is thick, she feels weak and depressed, all work is an effort, she has shortness of breath on exertion and occasional nausea. Her weight has increased 20 lbs. All changes have reached a maximum in the past six months.

Examination shows a middle-aged woman 5 ft. 9 in. tall, weight 151 lbs. She has a sluggish appearance, with a puffy, wrinkled face and folds about her eyes, the skin is thickened, dry and pale, the hair dry and coarse. Speech is slow and drawling, thought and action are correspondingly slow. The eyes react to light and accommodation. The thyroid contains multiple adenomata, the right lobe measuring 2x3 inches and the left lobe 1x1 inch. No bruits or thrills are evident. There is no tremor of the hands. Heart, lungs, abdomen and pelvis are negative. The reflexes are retarded. The syst. blood pressure is 150, the diast. 115 and pulse 80. The urine is negative. The blood shows 78% hemoglobin with 3,950,000 reds and a color index of 1. The leucocytes numbered 6,800. The differential count gave 53 lymph., 1.5 tran., 43.5 neut., 1.5 eosin., .5 bas. The basal metabolism was 28% below normal.

Ten mg. of thyroxin was given to this patient intravenously. This was followed in 12 hours by very severe general aching, which persisted for several days. In the meantime a complete change occurred in her appearance. Her face and body in general lost the puffy appearance. Her speech, thought and motions were speeded up, so that she soon gave the appearance of a normal individual. A second 10 mg. was given on the 9th day, and this was followed by oral medications in the third week.

This case is of special interest, because of the co-existence of myxedema and an adenomatous thyroid. Plummer in a series of 54 cases reported no case showing any evidence of thyroid enlargement. It is interesting to note that after the first dose of thyroxin the adenomata rapidly decreased in size, so that they are now barely palpable.

POST-OPERATIVE MASSIVE COLLAPSE OF THE LUNG: REPORT OF A CASE*

J. A. Beals, M.D.,
Jacksonville.

Post-operative massive collapse of the lung is a subject which should be of interest to every

*Read before the Riverside Hospital Staff, Jacksonville, April 27, 1926.

doctor who examines a chest, or uses a bronchoscope, or does X-ray diagnosis, or operates. Probably a more expressive term than "collapse" is "atelectasis," which is a diminution in the size of the lung resulting from the obliteration of the alveolar spaces. This condition is brought about by the closing together of the alveolar walls and not from the accumulation of fluid within them.

Though we had read of this alarming condition, I must confess, we were skeptical of its existence until the following experience: On the 5th day of last month at 11 a. m., Mr. T. B. P., age 22, left the operating room where he had had a double repair for bilateral recurrent inguinal hernia. He passed an uneventful day following his operation although his temperature at 8 o'clock was 100.5 degrees and pulse rate 96.

Upon arriving at the hospital the following morning the nurse greeted me with, "Dr. Jelks, it looks like we are in for trouble; Mr. B. is complaining of pain in his right side and looks bad." She was right. The patient was restless, cyanotic, gasping with rapid respiration and severely apprehensive. From an immediate medical consultation I received the report that Mr. B. "has an embolus and looks as though he were dying." The patient's appearance certainly justified such a statement.

A quotation from the medical examination made at this time is as follows: "At 3 a. m. awakened complaining of 'tightness in the chest, etc.' Was restless for a short while, went to sleep in few moments. Slept until 8:30 a. m. After morning bath still complained of some tightness. At 9:30 a. m. began complaining of slight pain just to left of sternum about 4th intercostal space. This became severe until about 10 a. m. Was slightly syanotic, breathing very rapidly and shallow, respiratory movements confined to left chest. Right chest retracted slightly anteriorly and moving laterally in the axilla. Percussion note hyper-resonant. No breath sounds heard over right chest, anteriorly or in axilla. Patient not turned. Breath sounds accentuated over left chest. Heart not grossly displaced, pulse rate about 110, temperature 99.4 degrees. Prescription morphia grs. ¼ and atropine grs. 1/150. Condition remained about same up to 12:30 p. m. Then became quite syanotic, with pulse of 160, temperature 100.6 degrees; profuse perspiration. Right chest unchanged. Lower left anteriorly hyper-resonant. No breath sounds; was given digifoline and morphia; placed in Fowler's position with almost immediate relief. Slight cough, no expectoration." At this time note was made that heart is definitely to the right of midline.

"At 4 p. m. chest condition unchanged, pulse 142, respiration 44 and temperature 102 degrees. Feeling much better. At 8:00 p. m. heard coarse ronchi to and fro; could be heard over entire right chest with fair expansion of upper portion. Patient much better, no pain or discomfort, temperature 101 degrees, pulse 130, respiration 138."

The next morning, the second after the operation, the picture was changed completely; apprehension was replaced by confidence, the patient did not look sick. He greeted me with, "Doctor, I gave you all a good scare yesterday. I'm going to get well." Although his temperature rose to 104.4 degrees, pulse to 130 and respiration rate to 40, the severe shock and apprehension were gone. The temperature steadily returned to normal, taking about ten days. By the fifth day the pulse and respiration were normal and remained so. The abnormal physical signs did not clear up for about two weeks. During this time there persisted an area of dullness in the right lower back with ronchi, loud crackles, and diminished breath sounds. The most characteristic finding is the displacement of the heart to the right side. This persisted and was very evident on the fourth post-operative day. Patient refused X-ray examination.

In summary: A young male adult the day following herniotomy developed suddenly a condition of dyspnœa, cyanosis and shock with elevations of temperature, pulse and respiration. The physical findings of the right chest were loss of respiratory movements, retraction of the chest, hyper-resonant percussion note and no detectable breath sounds. Most important of all the heart was displaced definitely to the right. He made a steady, uneventful subjective and objective recovery.

In attempting to discover what pathology could give such a clinical picture the first conditions that come to one's mind are:

1. Embolus.
2. Pneumonia.

1. Embolus does not explain the hyper-resonant tympanitic chest, the absence at all times of blood in the sputum, and the happy convalescence.

2. Pneumonia rarely develops so rapidly as to give the extensive shock. Besides, the physical

signs and progress are not those of pneumonia.

These conditions do not explain the displacement of the heart to the right side. It appears that something happened to increase the negative pressure in the right chest which drew in this direction the mediastinum and heart. Consolidation and embolus could have no immediate effect upon the cardiac position. Pneumo-thorax with collapse of the lung, diminishing or destroying the negative intra-thoracic pressure, would allow the mid-thoracic structures to be drawn over to the opposite side. While simple collapse or contraction of the lung, by lessening the size of the thoracic contents, would increase the negative pressure and pull the heart in its direction. We believe this is just what happened in the case in question.

For years a condition similar to this has been recognized when a foreign body totally obstructs a large branch of the bronchial tree. Distal to the obstruction the air within the lung is absorbed, causing a contraction of the lung with increasing negative pressure and a drawing of the heart to the side of the foreign body. Later when infection of the lung occurs with a filling up of the alveolar spaces with exudate, thus diminishing the negative pressure or when the obstruction to the bronchi is relieved and the lung distends, the heart returns to its normal position. May it not be then, that massive collapse of the lung results from mucus plugging the bronchial tree?

Our knowledge of "massive collapse" has developed largely from an observation of W. Pasteur made upon patients having collapsed lungs at autopsy when they had had in life paralysis of the diaphragm or other muscles of respiration. He noticed this especially in those with diptheritic paralysis. It is in his publication by the British Surgical Journal during 1914 and the article of Scott in Archives of Surgery, January number for 1925, that we have our most complete studies of this condition. Scott has reviewed all the published cases. He found only thirty-eight and added four of his own to the list. They vary in degree from the extensive type, of which ours was a good example, to those in which only part of a lobe is involved. However small the lesion, there has been noted always a displacement of the heart to the affected side. The elevation of temperature has been from just above normal to 104.3 degrees. The pulse has been as high as 160 and the respiration 60 to the minute. The X-ray picture is, of course, diagnostic and should not be confused with any other condition.

Though there is great uniformity in the observations of signs and symptoms, observers are not agreed upon etiology.

There are three theories of explanation—the paralytic, the obstructive and the reflex.

1. Pasteur is the author and chief advocate of the paralytic theory. It is based upon his observation of collapsed lungs at autopsy in patients with paralysis to the respiratory muscles. The diaphragm does ascend in paralysis, but how could this change the position of the mediastinum toward the affected side? Lange has observed in phrenicotomy for paralyzing the diaphragm in the treatment of tuberculosis that the position of the heart frequently is displaced to the side opposite that of the nerve section.

2. Arguing from similarity to the condition found in obstruction to the bronchial tree by foreign bodies, the obstructive theory would be very plausible. Secretions following anæsthesia causing bronchial obstruction would be a simple explanation did it not occur after the employment of local as well as inhalation anæsthesia. Besides, in most cases it cannot be proven that obstruction exists. There is frequently no sputum at all.

3. The reflex theory Scott thinks is the most likely explanation. Evidence in its favor is: first, collapse occurs usually after abdominal operations not likely to disturb respiration, that is, those below the umbilicus; second, it may appear in the chest on the side opposite to that of the operation; third, it was recognized in some war wounds of the thoracic wall in which there was no perforation. It seems to Scott to be an active contraction of the involved lung rather than a collapse from absorption of the alveolar air.

My thinking of this subject has suggested to me that many cases diagnosed post-operative pneumonia and other pneumonia for that matter, may be, in reality, primary lung collapse with secondary infection of the atalectatic areas. Are we overlooking this interesting condition? A physician from Spokane, Washington, told me this month that since reading Scott's article he had recognized three cases.

The condition must be diagnosed definitely if the proper treatment is to be given. It requires only symptomatic therapy, while pneumonia and embolus demand prompt and persistent attention.

A diagnosis is equally as important from the point of view of prognosis. Unlike embolus with its extremely high mortality and differing from so-called post-operative pneumonia with its tendency to complications and danger to life, uncomplicated post-operative massive collapse of the lung is yet to cause its first recognized death.

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STATE BOARD OF HEALTH NOTES

June 8th, 9th and 10th at the Duval County Hospital, Jacksonville, there was held a post-graduate short course for the study of venereal diseases, their diagnosis and treatment. The course was arranged by the Communicable Disease Bureau of the State Board of Health with the cooperation of the U. S. Public Health Service, represented by Dr. O. C. Wenger, the American Social Hygiene Association, represented by Dr. Walter M. Brunett and nine specialists of Jacksonville, viz: Dr. E. T. Sellers, Dr. F. C. Jones, Dr. Ralph N. Greene, Dr. J. L. Kirby-Smith, Dr. B. F. Woolsey, Dr. R. W. Blackmar, Dr. Robert B. McIver, Dr. T. S. Field and Dr. Shaler Richardson.

The morning sessions were taken up with lectures, clinics were held in the afternoon and on the first night pictures were shown. Certain other hours were set aside for recreation.

The program was specially arranged for general practitioners who, for various reasons, cannot refer their patients to specialists.

The course was taken by fourteen physicians from widely scattered sections of the state besides six Jacksonville doctors who attended.

There were some lively and profitable discussions. Those in attendance speak highly of the program and the men who took part in it and the hope was expressed that the short course might become an annual affair.

Gratitude of the Director and of those in attendance is extended to the physicians who gave of their time and skill and to the Duval County Hospital management for their cooperation and the use of the hospital.

During the month of June, every physician in the state should have received an A.M.A. Directory information card. Every one is urged to fill out and return the stamped card regardless as to whether he or she has changed their residence or office address.

This information will be used in compiling the Tenth Edition of the *American Medical Directory*, now under revision in the Biographical Department of the Association. The Directory is one of the altruistic efforts of the American Medical Association and is published in the interest of the medical profession which means ultimately in the interest of the public. It is a book of dependable data concerning the physicians and hospitals in the United States and Canada.

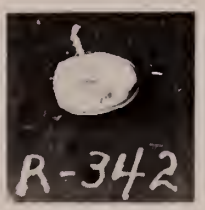
FOREIGN BODIES IN THE FOOD AND AIR PASSAGES*

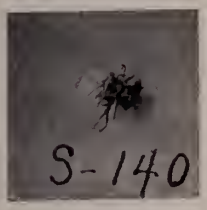
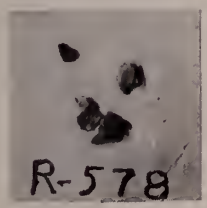
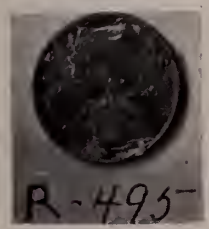
William Jerome Knauer, M.D.,
Jacksonville.

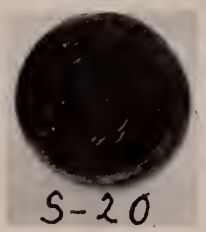
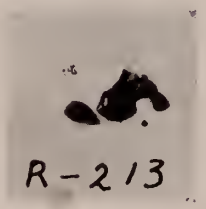
As we should ever have our records for handy references, so that, in attempting a case, we might profit by past experience, I am hereby presenting a series of foreign bodies with summarized records. The cases presented here were patients from all parts of Florida and Georgia. It is hoped that this summary will stimulate the practitioner to become familiar with the symptoms of these cases in order that the patient might come under the care of the bronchoscopist and esophagoscopist earlier. As will be noted in this series, seventeen of the thirty-two patients were allowed to go longer than twenty-four hours before being brought to the endoscopist.

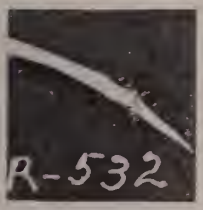
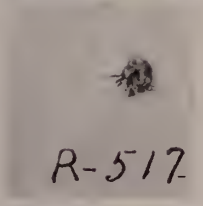
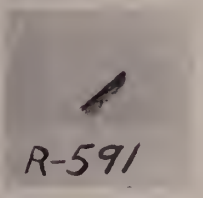
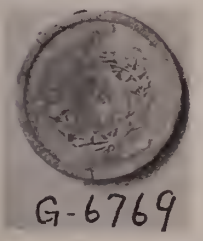
A careful history will nearly always give one a clue as to a foreign body. An X-ray should always, where it is possible, be done. If after the sudden swallowing or aspiration of any foreign substance or body the patient should complain of dysphagia and pain, or have frequent attacks of coughing with an asthmatoid wheeze (heard at the open mouth on expiration), one should always be on the lookout for a foreign body.

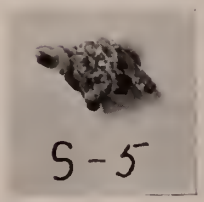
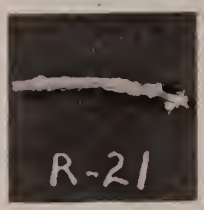
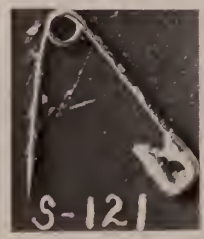
*Read before the Staff of Riverside Hospital, Jacksonville, May 25th, 1926.

Record No.	Age	Foreign Body	Location	Anæsthetic	Tube	Result	Time	Route	Comments
	7 yrs.	Sandspur	Right Bronchus, small piece in Left 4 days	None	5 m.m.	Extraction cure	7½ min.	Oral	
	12 yrs.	Straight pin	Midway Esophagus 3 hours	None	7 m.m.	Extraction cure	2 min.	Oral	
	7 yrs.	Straight pin	Esophagus	None	5 m.m.	Extraction cure	1 min. 30 sec.	Oral	
	8 yrs.	Sandspur	Lower Trachea 4 hours	None	7 m.m.	Extraction cure	6 min.	Oral	
	12 mos.	Watermelon seed	Hard palate 3 weeks	None		Extraction cure	1 min. 30 sec.	Oral	The watermelon seed resembled a growth of some sort. The family doctor had a Wassermann taken. Two Ear, Nose and Throat men proclaimed it a growth.
	3 yrs.	Grain of corn	Lower R. Bronchus 1 week	None	5 m.m.	Extraction cure	22 min.	Oral	

Record No.	Age	Foreign Body	Location	Anæsthetic	Tube	Result	Time	Route	Comments
K-504 (FISH BONE LOST)	39 yrs.	Fish bone	Upper Esophagus 1 hour	None	10 m.m.	Extraction cure	2 min.	Oral	
	3 yrs.	Sandspur	Trachea 1 week	None	5 m.m.	Extraction cure	7 min.	Oral	
	27 yrs.	Chicken bone	Lower Esophagus 3 hours	None	10 m.m.	Extraction cure	8 min.	Oral	Much food had to be removed before bone was located.
	13 mos.	Coffee bean	L. Lower Bronchus 12 days	None	5 m.m.	Extraction cure	31 min.	Oral	Baby was chewing the coffee bean, when it was suddenly scared and aspirated parts into lung.
	2 yrs.	Penny	Cardiac end of Esophagus 6 weeks	None	5 m.m.	Penny passed into stomach probably from gagging			Penny remained in stomach 2½ days before passing into small intestine.
	7 yrs.	Sandspur	Larynx 2 hours	None	Laryngoscope	Extraction cure	3 min.	Oral	

Record No.	Age	Foreign Body	Location	Anæsthetic	Tube	Result	Time	Route	Comments
	10 yrs.	Sandspur	Trachea	None	7 m.m.	Extraction cure	5 min.	Oral	
	30 yrs.	Fish bone	Upper Esophagus 2 days	None	Laryngoscope	Extraction cure	3 min.	Oral	
	12 yrs.	Sandspur	Larynx	None	Laryngoscope	Extraction cure	6 min.	Oral	
	4 yrs.	Nickel	Lower Esophagus 6 weeks	None	5 m.m.	Extraction cure	12 min.	Oral	Coin had made a false pocket, which was overridden on first two inspections.
	5 yrs.	Small chewed up pieces of spice	Lower L. Lobe 4 weeks	None	5 m.m.	Extraction cure	25 min.	Oral	
	3 yrs.	Fish bone	Beginning R. Bronchus 2 weeks	None	5 m.m.	Extraction cure	31 min.	Oral	There were two large papillomas of vocal cords which had to be removed before I could enter trachea.

Record No.	Age	Foreign Body	Location	Anæsthetic	Tube	Result	Time	Route	Comments
	21 mos.	Peanut	R. Lower Bronchus 36 hours	Ether	5 m.m.	Extraction Tracheotomy			Death 3 days later. Probably Embolus.
	50 yrs.	Fish bone	Midway down Esophagus 1 day	None	10 m.m.	Extraction cure	4 min. 30 sec.	Oral	
	16 yrs.	Sandspur	Cardiac end of Esophagus 5 days	None	10 m.m.	Extraction cure	1 min. 40 sec.	Oral	Football player.
	40 yrs.	Fish bone	Beginning of Esophagus 1 day	None	Laryngoscope	Extraction cure	3 min.	Oral	
	2½ yrs.	Nickel	Beginning of Esophagus 3 days	None	Laryngoscope	Extraction cure	50 sec.	Oral	
	23 yrs.	Stem of match	R. Lower Bronchus 15 days	None	7 m.m.	Extraction cure	12 min.	Oral	
	6 yrs.	Can opener	Esophagus 1 hour	None	Laryngoscope	Extraction cure	1 min.	Oral	

Record No.	Age	Foreign Body	Location	Anæsthetic	Tube	Result	Time	Route	Comments
	2 yrs.	Watermelon seed	R. Bronchus 6 weeks	None	5 m.m.	Extraction cure	8 min.	Oral	V. cords very edematous for 24 hours.
	60 yrs.	Pork bone	Midway down Esophagus 3 days	None	10 m.m.	Extraction cure	12 min.	Oral	Had to remove 2 ounces of food before bone could be located.
	21 yrs.	Fish bone	Upper Esophagus 8 hours	None	7 m.m.	Extraction cure	2 min.	Oral	
	48 yrs.	Fish bone	Beginning of Esophagus 4 hours	None	Laryngoscope	Extraction cure	1 min.	Oral	
	43 yrs.	Fish bone	Pharynx 4 hours	None	Laryngoscope	Extraction cure	1½ min.	Oral	
	51 yrs.	Fish bone	Mid-Esophagus 1 day	None	10 m.m.	Extraction cure	9 min.	Oral	
	4 mos.	Safety pin point up in tissue	Beginning of Esophagus 2 hours	None	5 m.m.	Extraction cure	3 min.	Oral	Pin had to be turned around before extraction could be done.

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THE KOLMER TEST

It is frequently said, in criticism, that the State Board of Health Laboratories should adopt the quantitative Kolmer technique as the routine test for syphilis. Recently the Board did adopt the qualitive Kolmer, which is an improvement over the Wassermann, but does not compare in value, especially in treated cases, with the quantitative Kolmer.

The quantitative Kolmer test is, no doubt, the last word in the serological diagnosis of syphilis. It detects cases of syphilis that the qualitive, or the old routine Wassermann method will not detect. In following cases of syphilis under treatment, the Kolmer test continues to be positive long after the Wassermann has become negative, and is thus a better and safer serological guide to treatment. The quantitative Kolmer test will give definite reaction in cases of latent syphilis.

neurosyphilis and congenital syphilis in which the other tests are negative.

The quantitative Kolmer test is an elaborate, delicately adjusted super-sensitive six-tube complement fixation test for syphilis, which is being used in the leading clinical laboratories throughout the country.

The Florida State Board of Health Laboratories, however, are not clinical laboratories. They are public health laboratories whose function is to detect communicable disease for the purpose of public health protection. Syphilis is only a communicable disease while it is in its early or initial stage. During this stage, the Wassermann, or qualitive Kolmer tests, are usually sufficiently sensitive to render a positive diagnosis, and, after it has done so, the duty of the state laboratory in regard to this case has been fulfilled; since, after treatment has been instituted, the patient is no longer a public health problem. The state laboratory should not be called upon to perform Wassermann tests on treated cases of syphilis or on latent, congenital or neurosyphiletic cases, since such cases are practically never communicable.

For the state to adopt means for the detection of non-communicable diseases is just another step in the direction of state medicine, which the medical profession is in no mood to tolerate at the present time.

The sending of specimens from non-communicable syphilis is liable to result in erroneously negative reports, which is not only misguiding to the physician in charge of the case, but is an injustice to the patient himself. All specimens, except of a strictly public health nature, should be sent to a private clinical pathologist.

H. Mason Smith, M.D.

THE GORGAS MEMORIAL

As the plan of the Gorgas Memorial to raise individual health standards by developing closer co-operation between scientific medicine and the public is becoming better known, its influence is increasing proportionately.

The Memorial was established by a group of physicians and laymen of national reputation to immortalize the signal achievements of General William Crawford Gorgas, that "Soldier of the World," whose life was a relentless battle against disease and whose contribution to human happiness and economic progress cannot be estimated.

It is not a monument of stone or bronze but a living working organization. Its object is to check the present needless waste of human resources by educating people to conserve their health, primarily through the medium of the periodic health examination by the family physician, and secondly by co-operating with all recognized agencies working for better health.

Under the auspices of a group of prominent citizens, with President Calvin Coolidge at the head, the Memorial is functioning in every state in the Union. The machinery through which it operates in each state is the Governing Committee, composed of representative physicians, dentists, and laymen in the state. In those states where the Committee membership quota is completed, or nearly so, a Chairman, Secretary, and various sub-committees have been appointed and systematic campaigns to reach the people of the state are being conducted.

Approximately 2,500 members have been organized in these Governing Committees and it is due to their co-operation and support that we are able to report the encouraging progress of the Memorial to date.

The ignorance of the public in matters pertaining to individual health is due in large measure to medical conservatism. With the steadily increasing menace of irregulars, cultists, and charlatans, the thinking members of the profession have come to realize their responsibility in the direction of properly health-educating the people depending upon them for guidance. The medical profession has a message to deliver to the public of far more importance than that of any other group.

In a recent article prepared for the Gorgas health series, Dr. Charles Mayo said:

"In the past twenty-five years more has been accomplished in medicine than in all the centuries before. Scientific medicine has done about all it can for the mass diseases, now practically gone, but which used to frighten and destroy the people by tens of thousands.

"Today each man is dying his individual death, and it is up to us to see if we cannot reach him in some manner and persuade him that it is worth while, when he is still vigorous, to learn to keep his machinery from going to pieces from neglect.

"To combat this unnecessary suffering and

waste of human resources, to induce better health and longer lives, a campaign of health education such as is now being undertaken by the Gorgas Memorial Institute is of the highest value.

"An important phase of the work is the periodic health examination or health audit, the only known way of discovering certain incipient diseases before the individual realizes anything is wrong. In the beginning Bright's disease, apoplexy, and high blood pressure are usually symptomless to their victims. But discovered in time by the health audit, the advice of the family doctor followed out, you are put on the road to recovery before your vital organs are wrecked beyond repair. Take as good care of your health as you would of your automobile and have your vital structure tested yearly to locate the enemy of your health."

The Gorgas Memorial has taken upon itself this task, namely, to promote a public opinion that will co-operate with and be receptive to the guidance of the scientific medical profession. The individual will be shown why it is to his advantage to co-operate with the state, county, and local health departments in their efforts to control disease. He will be told why, by supporting proper health legislation, living hygienically and in conformity with well-established health principles, he is benefiting himself and his family. He will be educated to distinguish between the legitimate practitioner of scientific medicine and the charlatan.

To reach the "man on the street" the Gorgas Memorial is utilizing existing channels of publicity, such as the daily newspaper, the general and special magazines, the radio, moving pictures, and talks before clubs and community gatherings. A series of articles on popular health subjects, written by the State Governing Committee members, is being distributed to the newspapers of the country, and reaching 20,000,000 readers regularly; this will be steadily extended until a daily service has been established and a larger circulation obtained.

A similar encouraging response has been accorded the radio program. Gorgas health talks are now being broadcast weekly by State Governing Committee members over many of the largest stations of the country.

Articles on the Gorgas movement have appeared in the Saturday Evening Post, Literary Digest, World's Work, and McClure's.

In recognition of Gorgas' contribution to the development of that country, the Republic of Panama has donated a site of ground and authorized the floating of a $750,000 bond issue to finance the construction of a laboratory in which tropical research will be conducted, under the supervision of a scientific board, of which Dr. Richard P. Strong of Harvard is Director.

Pending the completion of the Gorgas Memorial laboratory, the use of the Santo Tomas and Ancon Hospital laboratories has been tendered the Institute and plans are now being made to get the tropical research program started some time this year.

In order to support a project of such wide scope effectively, a $5,000,000 Endowment Fund is being raised. This fund will be invested in trust securities and the income only utilized to maintain the work. A certain proportion of the funds raised in each state will be set aside for activities in that particular state, under the direction of the State Governing Committee.

The medical profession has helped to get this movement under way. The contributions of our State Governing Committee members have made it possible to start the educational work and set aside a certain amount to the trust fund for investment.

The public in general will be invited to support financially and morally this co-operative lay and medical movement to raise individual health standards and extend the span of life by utilizing in a practical way the accumulated scientific knowledge of the centuries now in the possession of the medical profession.

Every member of a State Governing Committee is asked to co-operate in completing his committee. Beginning this fall, a series of public meetings will be held in the states whose quotas are complete.

The Gorgas Memorial has no intention of duplicating the work of any other organization. It has no desire to supplant any recognized activity working for health betterment. Its purpose is to urge everyone to encourage all reputable agencies working toward the common goal —good individual health; and to support the scientific medical profession in its efforts to broaden and lengthen the span of life. The control of health affairs belongs in the hands of the scientific medical profession as represented by the practicing physician. The Gorgas Memorial purposes to instil that idea in the public mind—so that it may be educated away from charlatans and cultists, and directed to qualified practitioners of medicine.

STATE NEWS ITEMS

Dr. Herbert Bryans, Jr., of Pensacola, is in Cincinnati on a visit.

Dr. Donald Babcock of Miami has sailed for London to do post-graduate work in orthopedic surgery. He expects to return to Miami about December 1st.

Dr. E. W. Warren of Palatka is spending several months in Europe. He recently sailed from Quebec and expects to visit many of the European clinics and return to Florida some time in the late fall.

At the last meeting of the Escambia County Medical Society, it was voted that the Society should disband until the September meeting.

Dr. A. K. Wilson of Jacksonville has gone abroad for some weeks' study in European clinics.

Dr. F. Clifton Moor, secretary of the Second District County Medical Society, was a visitor in Jacksonville recently and called at headquarters office. All members of the Association who visit or go through Jacksonville are requested to call at the office and make suggestions relative to the work of the Association.

Dr. J. T. Denton of Sanford will visit friends in Mississippi and Washington, D. C., for two weeks. In July, August and September, he will take post-graduate work in Pediatrics in the Post Graduate School and Hospital, New York, returning to his practice on October 1st.

The Florida Medical Association has increased its membership to 1010. It is with great pleasure that the administration makes the announcement of the fact that our membership now exceeds the 1,000 mark. It is hoped that during the present year several hundred more members will be added to our roster. Let each member of the Association assume the obligation of bringing into the Association all eligible practitioners of medicine in Florida.

The Manatee County Medical Society shows a membership of twenty-one with 100% of its membership dues paid. Congratulations to Manatee County Medical Society for this record. Dr. J. M. Davis, secretary-treasurer, reports that the monthly meetings are well attended, quite delightful and most profitable—a fine record.

Dr. J. H. Bickerstaff, of Pensacola, is planning to leave soon for Vienna for work in the Clinics.

The wife of Dr. Percy F. Lisk of Ft. McCoy died the last of May. Doctor Lisk is now in St. Augustine and expects to remain there until in August when he will return to Ft. McCoy.

Dr. F. A. Copp of Jacksonville has gone abroad for some months' study in the dermatological clinics of Europe. Doctor Copp expects to return some time during the late fall.

Dr. Clarence Hutchinson, of Pensacola, is entertaining Mr. Kurns, President of the Frisco R. R. System, on a two weeks' fishing cruise in West Florida waters.

At the time this JOURNAL went to press there were a total of seven county societies showing 100% of their membership whose state dues were paid in full. The names of these societies and number of paid members are listed below:

Bay County Medical Society.....	7
Bradford County Medical Society..	5
Brevard County Medical Society..	7
Broward County Medical Society..	14
Lake County Medical Society.....	16
Manatee County Medical Society..	21
Sarasota County Medical Society..	13

Dr. E. W. Bitzer of Tampa is spending some time in Europe, visiting clinics. He expects to return about December 1st.

Dr. H. L. Simpson, of Pensacola, is expected home the latter part of this month from an European tour.

Dr. C. M. Mitchell of Sanford is visiting friends in Georgia after which he will spend a few days in Washington, Philadelphia and New York, returning to his practice in Sanford about the twentieth of July.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES
FLORIDA MEDICAL ASSOCIATION

		MEETINGS			
County Society	Secretary	Date	Time	Place	Luncheon?
Alachua	W. Lassiter, M.D., Gainesville.				
Bay	J. M. Nixon, M.D., Panama City.				
Bradford	Seeber King, M.D., Lake Butler.				
Brevard	R. D. Ferguson, M.D., Titusville.				
Broward	R. Hippensteel, M.D., Ft. Lauderdale.	Monthly	8:00 P.M.	Ft. Lauderdale High School	No.
Columbia	L. J. Arnold, M.D., Lake City.				
Dade	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.
DeSoto	C. H. Kirkpatrick, M.D., Arcadia.			Hospital	No.
Duval	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.
Escambia	Herbert D. Snyder, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.
Hillsboro	B. W. Lowry, M.D., Tampa.	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.
Jackson	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.
Lake	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.
Leon-Gadsden .	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.
Manatee	J. M. Davis, M.D., Bradenton.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.		Dixie Grande Hotel	Yes.
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.
Monroe	G. R. Plummer, M.D., Key West.				
Orange	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Announced	No.
Palm Beach ...	W. O. Arnold, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Monterey Hotel	Yes.
Pasco	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every 2nd Friday	8:00 P.M.	Fla. Art School	No.
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr. June, Aug. Oct., Dec.		Lakeland	Yes.
St. Johns	I. M. Hay, M.D., St. Augustine.				
St. Lucie-Okeechobee	G. C. Hardie, M.D., Ft. Pierce.				
Sarasota	F. Metzger, M.D., Sarasota.				
Sumter	W. E. Mitchell, M.D., Coleman.	Monthly			No.
Taylor	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.
Volusia	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.
Walton	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.

NOTE
(Secretaries: Please submit information to complete the above schedule.)

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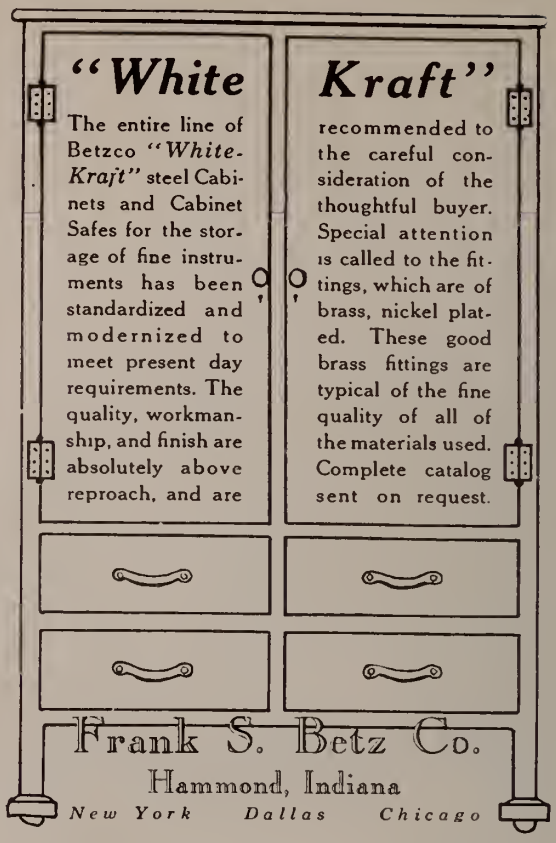
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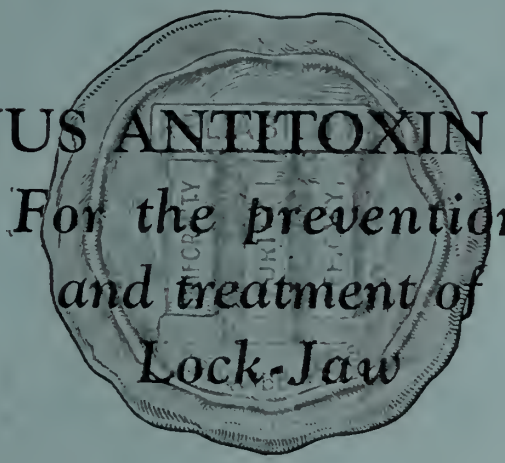
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CONTENTS

PAGE

A Plea for More Judgment in Correcting Uterine Displacements 28
J. S. Turberville, M.D., Century

The State Board of Health, Its Anatomy and Physiology 31
B. L. Arms, M.D., State Health Officer, Jacksonville.

Additional Scraps From Memory's Storehouse of Sanitary Deeds in Florida During the Past Half Century 33
Joseph Y. Porter, M.D., Key West.

Advancements in the Treatment of Atrophic Rhinitis with Ozena 47
Walter T. Hotchkiss, M.D., Miami Beach

PAGE

Case Report: Swallowed Foreign Body, Causing Marked Emphysema 50
John H. Beals, M.D., Jacksonville.

State Board of Health Notes 51

Editorial: The Accidental Insufflation of Stearate of Zinc 52

State News Items 53

Schedule of Meetings—Component Societies Florida Medical Association 57

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
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A PLEA FOR MORE JUDGMENT IN CORRECTING UTERINE DISPLACEMENTS*

J. S. Turberville, M.D.,
Century.

I come to you, not with a new subject, but with one over which there seems to be much confusion as to indications for treatment as well as what kinds of treatment to apply.

It has been the custom in the past, by most writers, to regard all displacements, particularly retro-displacements, as pathological, and some kind of treatment instituted.

There is general agreement that there does exist congenital retro-displacements, but few have attempted to formulate rules for their determination. The rules formulated by most of them are inapplicable to multiparous patients. However, there is one exception, and that is Sturmdorf.

A few quotations will give an idea of what most authors think of displacements.

Operative Theropeusis—Johnson: "There is no doubt that many women have displacements of the uterus for long periods of time without unpleasant symptoms, but, as a rule, such displacements, if constant, eventually bring about changes in the circulation and function of the uterus, or disturbance of function in neighboring organs that cause them to seek relief; therefore, treatment of any form of uterine displacement depends not only upon a carful study of causes of the displacement, but upon a clear conception of the forces that maintain the uterus in its normal position."

Crossen—in his usual careful manner—Operative Gynecology—says: "There are good reasons for the present confusion. The subject is comparatively new. Certain factors in uterine support are not yet fully understood in physiologic conditions, and much less in pathologic conditions. There are, in most cases, associated lesions, the importance of which in the clinical picture have only in recent years begun to be appreciated."

Prior mentions three cases of congenital retro-versions in 4000 examinations. He further says: "Retro-position of the uterus is any position posterior to the normal, but does not always constitute a diseased state. My view is that not so much the displacement as the accompanying or causative lesions produce the symptoms."

Gilliam, in his Practical Gynecology, says: "There is no absolute fixed position of the uterus which may be denominated normal. The loss of integrity of the pelvic floor is by far the most potent factor in the causation of downward displacements of the uterus, and a contributory cause of the backward displacements. Occasionally, though rarely, a prolapse may occur in the multiparous woman, or even in the virgin. In such cases it will usually be found that a pelvic deformity exists, the sacrum being too straight and the vagina and uterus approximately in line. This, coupled with absence of muscular development, offers conditions favorable to descent."

These quotations are enough to show the general trend of opinion.

Most authors regard the normal position of the uterus as being corpus forward on the bladder, and when the latter is empty, the position is one on a level or just below the superior edge of the symphisis pubis, with the cervix pointing backward towards the last sacral vertebra.

The question of why it keeps this position is too great to be discussed in a short paper. However, I will say this, that the uterus is maintained in its position by the same forces that keep the other abdominal and pelvic viscera in position, and is subject to the same variations incident to abnormal development, muscular weakness and neighboring trauma. The one exception is that it is placed at the bottom of the abdomino-pelvic cavity, and is subjected to the overhanging weight of the other organs so far as the force of gravitation is operative within a closed cavity. The inclination of the pelvis, no doubt, is operative in deflecting the forces forward.

Levator lascerations disturb this balance by letting the posterior pole (cervix) drop downwards and forwards, which finally causes the anterior pole to fall backwards. It is evident, therefore, that correction of uncomplicated ac-

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

quired discenso-retro-displacement is repair of the levator ani muscle.

The main object of this paper is to try to formulate some rules by which we can determine the operative from the non-operative treatment of retro-displacements.

STURMDORF estimates that 18% of gynecologic patients present a retro-displaced uterus.

BARBOUR and WATSON, as quoted by Sturmdorf, estimate one-fifth of these as congenital. As their method for coming to this conclusion is very uncertain, I think we may disregard it entirely.

Sturmdorf has a rule based on skeletal poise, which I have followed for ten years, and have verified it almost daily, and which, so far as I am concerned, is correct. This is based on the depth of the lumbar curve. The patient is instructed to stand in a comfortable and normal position, and a desk ruler or some straight-edge instrument is placed so as to span the highest points of the dorsal and sacral spine, and the deepest portion of the lumbar curve is measured. This he calls the sacro-vertebral angle, or index, and is a measure of the pelvic dip. This factor was recognized by Gilliam, as shown in quotations above, but it was evidently not clear enough in his mind for him to formulate rules for its measurement.

Sturmdorf has made enough observations that he is able to formulate the following rule: "An index of 30 millimeters marks the extreme minimum compatible with normal ante-version of the uterus. *From 25 millimeters down, the existence of congenital retro-version may be positively predicated in nearly every case prior to its bimanual verification, and this regardless of multiparity and the other complicating factors that obliterate the differentiating criteria formulated by Barbour and Watson.*"

Barbour and Watson regard congenital retro-displacements as those where the uterus measures 2½ inches by sound, without history of inflamation or other cause, or, when replaced, shows a tendency to return. This applies to women who have not borne children. So far as I know, they do not attempt to differentiate this condition in multiparæ.

STURMDORF, according to the above rules, finds over half of the retro-displacements belonging to the congenital type, and require no treatment for the retro-displacement. Barring complications, he does not regard these as needing treatment directed to their uterus, but thinks it purely an orthopedic question.

Granting the correctness of Sturmdorf's findings, how are we to proceed in our investigations relative to the other 9%?

The condition of the pelvic floor should be determined, and the presence or absence of rectocele or cystocele observed. If there is retro-displacement it must be noticed whether it is a version or flexion. Enlargement of the uterus and edema of its posterior wall as well as complicating inflamations and adhesions looked for. The degree of descensus and the presence of inflamation of the adnexa must be determined. If the adnexa are inflamed, is it acute, sub-acute, or chronic? The general condition of the patient must not be overlooked. Weak and flabby muscles often indicate a general viceroptosis. Care should be taken to ascertain if the symptoms of which the patient complains can be honestly attributed to the genital tract, and in particular to the retro-displacement. It is necessary to make a close study of the whole menstrual and sexual life of the patient in order to properly evaluate her symptoms.

If the above data is obtained with an open mind, one will be able to group his patients into: Those needing no treatment directed to the genital tract; those needing only local medical treatment; those needing local medical treatment to reduce the size of the uterus, followed later by repair of the perineum; those needing prolonged general and local treatment, followed by repair of the perineum and whatever intra-abdominal work is necessary, and anchoring the uterus forward in any way that seems best. My own experience, and the observation of the work of others, lead me to think that we are too impatient and often rush into surgery before the patient has been properly prepared, with the result that we fail to relieve the patient completely, or if more time had been given to local and general treatment, no operation would have been necessary. I do not think it ever justifiable to do any of the intra-abdominal operations for bringing the uterus forward where there is free mobility and no enlargement and the adnexa are not involved. If the perineum needs repair, do this, but have the courage to stay out of the abdomen.

In the congenital type of displacement, do whatever is necessary, but do not disturb the displacement. One should never tell a woman she has a displacement without instructing her

as to its significance, otherwise you may make a well woman sick.

In the anterior positions there is practically never any indication for surgical treatment. The lateral deviations should have the cause removed, such as inflamed tubes and ovaries, and adhesions the result of these. The treatment of descensus is the treatment for retro-version, except in extreme cases where more radical measures should be used.

SUMMARY

Differentiate the congenital from the acquired displacements, and do not treat the displacements in the former. Prepare your patient by local and other treatment before attempting surgery, otherwise you may fail to relieve the patient. Have the courage to stay the hand unless you are sure that an operation is indicated. Do not make well women sick by discussing their genital displacements unless you are sure of their significance.

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DISCUSSION

Dr. W. M. Rowlett, Tampa:

I have enjoyed this paper of Dr. Turberville very much. It contains some wholesome advice if we live up to it. Displacements are conditions that most of us meet up with daily. I do not believe that our gynecological cases have prospered so nicely during the past two or three decades, in that stage which might be termed "experimental gynecological surgery", and I am convinced that a great many of these patients would have been better off if there had been no surgical interference.

To thoroughly appreciate what constitutes a displacement we first should become acquainted as to what the normal condition of the uterus is. It lies in practically a horizontal position to the body while standing. As you know, the anterior surface rests upon the bladder and is held there by the ligaments and musculature (the doctor omitting details, as it covered too much space). The ligaments and intra-abdominal pressure is what sustains the uterus in its normal position, which is slightly anteflexed, and unless there is some congenital condition, such as tumors, adhesions, or a condition that has produced a large boggy uterus—and your patient has been kept on her back too long during illness—we are not apt to have a retro-version. I believe, most of the cases of retro-version that have been produced were due to faulty technique on the part of the Obstetricians in keeping their patients too long in the dorsal position after parturition. It is well to have these patients, in twelve hours, moved from one side to the other, and after four or five days to have them lie on their abdomen for twenty to thirty minutes daily in order to prevent the large heavy uterus from falling back into the cul-de-sac and remaining there long enough to produce a stretched ligament, which loses its tautness and later results in retro-version—which also is apt to produce the so-called "one child sterility". This is a condition that every Obstetrician should guard against. The various operations for displacements I don't think should be attempted unless we are positive of our etiology or an existence of pathological conditions.

Dr. D. E. Edwards, Orlando:

I agree most heartily with Dr. Turberville and with Dr. Rowlett's remarks.

The title of the paper brings to my mind a phrase that I once read. Farmer Broadacre, talking to some neighbors, said of the local barrister, "and he, by canny judgment, is becoming master of us all". Now, that holds true today

as it did in the time when that story was set, and it holds as true for the doctor as for the lawyer.

The person who, by his knowledge and judgment, gets results is going to be the leading man in the profession. As I look back, year after year, and my practice has increased and I have the proper retrospect, I feel that it is not necessarily the canny judgment, but it is often the uncanny judgment which designates the diagnosis and proper treatment in cases of uterine displacement.

You know, we have two great primary instincts in the animal kingdom, that of self-preservation and that of reproduction of species. You can readily see that without sexual desire the human race would very rapidly disappear from the face of the earth. Now, take the female who has begun to run down and is becoming more and more neurotic. If she has been told that she has female disorders, she will immediately assign the whole train of symptoms, vague and active, to this displacement, although the displacement may have been there for ten to twenty years and the disorder of only two or three months' duration, and she will want treatment immediately for the displacement, and almost demand it, at times. That is, the primary instinct is there. She may not always know, of course, but she feels she is not normal, and that subconscious instinct and desire is there, and she wants to be made a normal woman—a perfect female.

CONCLUSION

Dr. J. S. Turberville, Century:

I have nothing more to say. It was just a mere sketch of the whole question—this subject would take a great big paper. I am much obliged to these gentlemen for their discussions.

The main reason for this being in my mind is that I have seen a good many post-operative cases appear with symptoms continuing after surgery. I think a lot of this kind of work is being done. I just want to sound a note of warning. I have a patient referred once in a while and find that the doctor has stressed a great deal the displacement. Lots of times, in my opinion, the displacement has existed for years, as one speaker has just said, and the disorders have nothing to do with the present symptoms. But it is on their mind. We should be very careful about telling people what we think unless we know what we are talking about.

THE STATE BOARD OF HEALTH, ITS ANATOMY AND PHYSIOLOGY*

B. L. Arms, M.D.,
State Health Officer,
Jacksonville.

In deciding on the subject to take for this paper, it seemed wise to consider our organization from two angles—its make-up and function.

In the early days of the State Board the anatomy was comparatively simple, but with the advance of our knowledge of preventive medicine this has grown more complex as has the function as well.

The State Board of Health consists of "three discreet citizens of the State" who are appointed by the Governor and confirmed by the Senate. The law directs that at the first meeting of the Board they shall elect one of their number president, and at the same meeting they shall "designate and employ a physician * * * which said physician shall be known as the State Health Officer." The State Health Officer is made Executive Officer and Secretary of the Board.

At present we have five bureaus and administration, and they will be discussed in the order of their addition.

Administration includes the general correspondence and business for the entire department—accounts, records and correspondence of the Orthopedic Department, care of buildings and property and multigraph are grouped here. Each Saturday morning we have a conference at which all bureau directors are present if they are at headquarters, but if absent, the bureau is represented by someone designated by the director, and all matters of interest are freely discussed. In this way all are familiar with what each bureau is doing and the work is coordinated as it could be in no other way.

The Bureau of Laboratories was the first separate division and now consists of the central laboratory at Jacksonville and branch laboratories at Tampa, Pensacola, Miami and Tallahassee.

The laboratories examine specimens to assist in the diagnosis and control of any disease or condition of a bacteriological, serological or parasitic nature dangerous to the public health.

The laboratories send containers for the various examinations on request, and any physician can secure this free service at any time. The

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

central laboratory at Jacksonville is also the main distributing point for the biologics furnished by the State Board of Health, consisting of diphtheria antitoxin for therapeutic use, toxin antitoxin, Schick test material, tetanus antitoxin for both prophylactic and therapeutic use, vaccine virus, typhoid vaccine and antimeningococcus serum. These are furnished free to all.

In addition to the above, antirabic treatments are furnished from the Jacksonville laboratory at cost for any human bitten by a rabid or supposedly rabid animal, and if the physician certifies that the case is indigent and that he is receiving no pay for the administration, this, too, is free.

In order that diphtheria antitoxin may be easily and quickly secured, certain drug stores, centrally located, have been designated as antitoxin stations, and at these stations a small amount of diphtheria antitoxin and typhoid vaccine is kept. NO OTHER STATE BIOLOGICS CAN BE SECURED FROM THESE STATIONS.

The Bureau of Vital Statistics began its work by collecting certificates of deaths and births, but not until 1919 did they have sufficiently complete reports to entitle Florida to a place in the Registration Area For Deaths, and in 1924 the State was included in the Registration Area For Births.

This bureau is really our bookkeeping department, not for financial records, but is the place where we can find if we are doing effective work, and the name for the work of the department, as given by the late Dr. J. N. Hurty, of Indiana, "The Bookkeeping of Humanity," is in line with its function. The work has grown immensely. For instance, one worker is kept busy all the time making certified copies of birth and death certificates. Birth and death certificates and reports of sickness are received and we are kept informed of health conditions in all parts of the State by means of these reports and certificates.

There is no section of the State that does not call on this bureau for some kind of assistance, and the full value of the records depends largely on you.

Some of you are cooperating fully with us to make our records of value, but, I regret to say, some of you do not report your cases as required. We ask the cooperation of all.

The birth and death records are bound and indexed and thus are available for immediate use. Each certificate of death from a reportable disease is checked, and when no report of the case is found the physician signing the death certificate is asked for that report. Don't take it for granted that someone else has reported a case, as it may save embarrassment to you later if you report all notifiable cases when they come to your attention. If the case has previously been reported, your report will be marked "duplicate" and you are safe.

The Orthopedic Department cares for indigent crippled children to the extent of its appropriation, but much more could be done if we had more funds. At present we have a waiting list that will take at least six months to reach the last in order.

In order to extend the work as much as possible, parents are expected to meet whatever part of the expense they can and every patient must have his fare paid to and from Jacksonville.

The Bureau of Communicable Diseases is really a continuation of Assistant State Health Officers and Agents of the State Board. The Medical Officers investigate outbreaks of disease and reported outbreaks, conduct campaigns of immunization, assist communities to prevent disease, assist in formation of health units, assist in examination of school children, conduct or assist in health educational campaigns in communities, etc. One may be vaccinating against smallpox in a community today, tomorrow taking swabs at a school where there has been a case of diphtheria, and explaining that it is no longer necessary for a child to have diphtheria and that they will gladly immunize all that present a request from their parents, or they can get the immunization from their own physician, and the next day he may be somewhere else and doing some other kind of health work. This bureau, in cooperation with the United States Public Health Service, also directs the venereal disease control for the State.

The Bureau of Sanitary Engineering, as the name indicates, has the supervision of water supplies and sewage disposal, general sanitation, inspection of tourist camp sites and certification of same with periodic inspection to see that the rules of the State Board of Health governing the conduct of tourist camps are observed, investigation of nuisances, investigation of mosquito-breeding areas, examination of water, certification of water for common carriers, examination of water bottling plants and certification of same, approval of plans for water supplies, sewer systems and swimming pools, supervision of the sanitation of shellfish areas and packing houses, sanitation of

dairies, markets, schools, jails and other public buildings. Quite a list of duties, but this is not a complete list of what they do.

The Bureau of Child Hygiene and Public Health Nursing reaches the rural homes and schools, and the nurses are doing a great deal by conducting pre-school and infant conferences to assist the mothers that the next generation may not show as great a percentage of defects as was found at the time of our entrance into the World War.

Neighborhood institutes are held and prospective mothers are shown how they can prepare for the advent by using what they have at hand with very few and inexpensive additions. The pupils at the one and two-teacher schools are inspected, and those pupils that show defects are advised to go to their family physician; hookworm campaigns are conducted in cooperation with the local people, for it is only when the local people are interested that we can really secure results. The midwives are seen periodically and a course of instruction is given and an examination is required. Since this was adopted the number has been reduced 41%. After passing the examination a certificate is granted, and this automatically expires December 31, and must be renewed annually following another examination if they wish to continue the work; it is recallable at any time for cause.

Conferences are arranged with various groups and health habits are stressed.

The great influx of tourists and the large number of people living in the camps made necessary the innovation of having nurses whose sole duty it was to visit these camps to aid the mothers and children who were many of them living under new conditions, hence needing guidance. This pioneer work has been valuable to the State and has been of great assistance to many of our visitors and prospective citizens.

While I realize that the foregoing has been sketchy, it is impossible to give complete detail in the time allowed, but the major functions of each department have been mentioned.

Each one of you is one of our employers, and it is our aim to serve you to the limit.

Some of you have visited your State Board of Health, for you must remember that it is your Board and we wish that every one of you would make us a visit and see what we are doing, how our records are kept, and let us know how we can give you better service.

Additional Scraps From Memory's Storehouse of Sanitary Deeds in Florida During the Past Half Century*

Joseph Y. Porter, M.D.,
Former State Health Officer of Florida,
1889 - 1917

(Supplement)

It will be remembered by those who were present at the meeting of the Florida Medical Association at St. Petersburg in 1925, that it was remarked, at the time when "Looking Backward Over Health Work in Florida for the Past Fifty Years" was read, that, with no records at hand to consult conveniently—the writer having relied entirely upon memory for arranging the events of this narrative in proper sequence—it was most difficult to tell in exact chronological order the various happenings in any line of endeavor for so lengthy a period. Memory, at best, is capricious, and many important events bearing upon a life-history connected with the development of a community or state may have thus been overlooked, not intentionally, but inadvertently, through amassing so great a wealth of material at one telling.

It is due, therefore, to this fickleness of mem-

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Editor's Note—*This paper supplements a serial article entitled "Looking Backward Over Fifty Years of Health Work in Florida", appearing in the Florida Medical Journal for the months of July, August, September, October, November, December, 1925, and January, 1926.*

ory that the writer omitted to mention other important subjects which are now recalled and have a direct bearing and influence upon health work in Florida. It is on that account that he desires to append this additional "memory scrap" to his first effort at recording health history in the state, in order that proper acknowledgment may be made to an organization whose influence and cooperation with the Florida State Board of Health was of inestimable benefit to its officials in its early days of health activity, although coming into active work in quarantine and domestic matters some years after the State Board of Health was organized. The U. S. Public Health Service, in rendering efficient aid and friendly assistance to state health authorities, has performed a real service to Florida, and due appreciation of this splendid spirit of cooperation should be expressed in this memoir.

The other omissions concerned the establishment of a Veterinary Division in the State Board of Health activities, and the inception and inauguration of corrective surgical treatment for indigent crippled children of the state as an activity, carried on under the auspices of the State Board of Health, which afforded succor to those handicapped by misshapen arms, legs, or bodies, and is still instrumental in transforming many a twisted little frame and contorted face into a semblance of what should be its normal appearance.

Florida has and still is passing through a wonderful change, not only in its topography but in its type of settlers, and so, expanding physically and financially, is undergoing a transformation almost kaleidoscopic in its swiftness; thus happenings of by-gone days seem unduly vague and distant by virtue of its tremendous stride toward progressive and enlightened living conditions. Yet it is hoped that these omissions in the narrative given to the Medical Association in 1925, at St. Petersburg, may be none the less interesting in that they typify the indomitable spirit that has caused Florida to forge ahead to better health conditions, contributing in no little measure to its present healthfulness and prosperity, and that the notebook of "Memory Scraps" may be permitted to be opened again to jot down additional facts, since they have had so potent an influence upon the pioneer days of health activity and are really worth mentioning.

With this explanatory premise and apology for forgetfulness, memory's "scrapbook" of happenings during half a century in health work in Florida is unclasped to permit a few otherwise blank pages to record events equally important for historical reference as those that have been hitherto noted.

The older citizens of the country will recall that in the early days of the Republic the general police powers of the states were scrupulously guarded by the advocates of "State's Rights", and laws and regulations pertaining to the protection of property, life and health were so carefully constructed that the conditions of each, according to environment, were duly observed, for "States' Rights" had been, at the initial stages of the Union, an especial political factor.

As far as can be learned, the first mention of Federal assistance to the States was in 1796, when Congress authorized the President of the United States to "direct officers of the Revenue Cutter Service to aid and assist in the execution of maritime quarantine laws of the sections of the Union bordering on the coast of the United States as well as to cooperate in the enforcement of the health laws of the States themselves." At that period in the history of the Republic, the Revenue Cutter Service antedated the organization of the Navy.

It was not until 1878 that Congress passed an Act creating a National Board of Health, which was short-lived, only functioning until 1883, when its activity and usefulness ceased through the failure of Congress to appropriate funds for its further maintenance.

The next attempt made by the Federal Government to assist the States in the health management of their affairs was later, in 1878, when Congress "imposed additional duties on the Marine Hospital Service" in the matter of interstate quarantine restrictions whenever dangerously epidemic diseases existed within a state, to prevent transmitting such diseases from one state to another by transportation line of passenger travel. This date was given in an address by Dr. John F. Anderson (who was at that time a surgeon in the Public Health Service) which he made before the Massachusetts Association of Boards of Health in Boston, in 1913. Dr. Anderson names this Act as "the first permanent quarantine Act passed by Congress". The States, through Congress, then had not acceded to the persistent demand of a central government and an encroachment on the principle of

"States' Rights", and did not very willingly assent to measures which might be developed into further trespass upon the inherent and sovereign powers of the States in regulating and controlling their own domestic affairs.

The disastrous epidemic of yellow fever in the southwestern States, which occurred at the period above referred to (1878), seemed to make necessary some statutory governmental regulation by which destructive contagious diseases occurring in one state should be excluded from transmission to another. This resulted in the invocation of Constitutional authority regulating commerce between the States, and Congress set out to perform what the States seemingly had only a partial ability to execute. Again, in 1893, when the widespread prevalence of cholera in Europe caused alarm in this country, Congress, through its Committees, made special inquiry regarding the health laws of sea-coast States' quarantine restrictions to prevent an entrance of this menace into this country, which might be amply sufficient, also, and to consider the advisability of further laws which should be enacted to protect citizens of this country against the possibility of cholera visitation.

One of these investigating Committees, with Senator Proctor of Vermont as Chairman, assisted by Senator Call of Florida, paid a visit to Cuba to ascertain whether there was a likelihood of cholera being introduced into the United States through Havana or any other sea-coast city of Cuba. At the request of Senator Call, the State Health Officer of Florida joined the Committee at Key West, accompanying them to Havana and participating in the deliberation held there.

The Act of Congress of February 15th, 1893, was broad in its application of quarantine methods, and placed additional duties of a maritime character on the Marine Hospital Service, then known as the Public Health and Marine Hospital Service. Reference to these regulations were made in a former treatise, in 1912, the name of the service was again changed to the Public Health Service of the United States, which title it still retains. It may not be irrelevant at this time to say that a resolution proposing this change of name and suggesting a general reorganization of the divisions of the bureau, was proposed by the representative of the State Board of Health of Florida at the meeting of the state and provincial boards of health in Washington in 1910. Again reference may be made to the former "recollections" presented in 1925 of the part played by the Florida State Board of Health in the formation of additional United States Rules and Regulations of Quarantine Management by the Public Health and Marine Hospital Bureau, of which Committee the late Surgeon Henry R. Carter was Chairman, immediately following the passage of the quarantine act of February 15th, 1893. It is pleasing to say to the physicians of Florida that a hidden compliment to Florida was given when these regulations were framed and printed by the adoption of many of the cardinal principles of maritime sanitation of the Florida State Board of Health, and which were incorporated into the U. S. Quarantine Regulations at this time; a comparison of the two amply satisfies this assertion.

The above facts are called to the attention of Florida physicians as indicating the small amount of assistance given by Federal Government prior to 1893.

The history of the United States Public Health Service, from its creation in 1871 to its present high standard of public health work, has been told by Dr. John F. Anderson when a member of the corps of medical officers of the service, and also by other medical men of the service in various monographs and addresses; the history of a service which has at all times reflected marked honor and credit upon itself and the country. Realizing, always, the limit of federal power authorized when functioning within the states, this fine corps of officers, scholarly and professionally trained, have given without ostentation, a cooperative hand of assistance whenever asked to help, in a professional capacity, or to assist in allaying fear, or acting as sanitary "peace officers". This was especially true, as far as Florida is concerned, between the years 1889 and 1917, when the writer had experience, by personal contact, in the incidents which are referred to. Doubtless, the same pleasant associations have been enjoyed by those who have succeeded to the executive office of the State Board of Health.

It is a pleasure to testify by name and to personally thank Dr. Robert Blue, the present living ex-Surgeon-General of the Public Health Service, the now executive Surgeon-General, Hugh S. Cumming, and to likewise pay tribute to the memory of Dr. John B. Hamilton and Walter Wyman, deceased, with an expression of high

regard for Drs. Robert Murray, Henry R. Carter and Joseph H. White, for the cordial and willing cooperation given, at all times, to requests made upon the service by the State Board of Health in matters of public health and sanitation which affected Florida. They made possible professional and financial assistance by efficient personal help when difficulties surrounded the State Board of Health in acquiring that speedy and prompt action so necessary in emergencies, yet momentarily embarrassing to the State to provide for upon short notice. To the heads of the different divisions of quarantine and other administrations, Drs. Glennan, White, Cofer, Anderson, Creel, Rosenau, and many others, whom to try to single out by name would be unfair to those unrecalled at this moment of writing, the grateful thanks of the writer is expressed. While this passage is being written, many delightful incidents of splendid cooperation and friendliness are recalled: consultations on quarantine matters pertaining to methods of improving the efficiency of the quarantine system in Florida, and to other moments of professional companionship which will always be happily remembered.

With but little of the spirit of arbitrary assumption of superior medical knowledge, these scholarly men, whenever detailed to assist in correcting sanitary troubles in Florida, were always welcomed with a genuine hospitality by the authorities of the Florida State Board of Health, and due appreciation of their services.

In the early 90s, an attempt was made to revive a National Board of Health by soliciting Congress to provide for a Department of Health with an executive secretary in the President's Cabinet of Councillors. Senator Owen, of Oklahoma, introduced the measure proposing to create a Department of Health, which was championed by some of the leading Medical Journals, Medical Societies, and individual medical men of the country. The idea seemed to be to wrest from the Marine Hospital Service the function of sanitary activity in preventive medicine, as nationally exercized by that Service, and center such energy for public health in a Cabinet appointment. The Florida Health Department thoroughly studied the situation, the practicability of operating under our form of government, and the possibility of accomplishing any greater degree of national sanitation than was then being carried on under the direction of the Public Health and Marine Hospital Bureau, which was in reality a Department of Health, although not so specifically titled. The views of the Executive Office of the State Board of Health of Florida were clearly and concisely set forth in the following article taken from "Health Notes" of August, 1911, a publication of the State Board of Health, which presented to the citizens of the State a monthly inventory of health and sanitary matters occurring each thirty days:*

"A PUBLIC HEALTH DEPARTMENT! IS IT ESSENTIAL TO PROGRESSIVE HEALTH MANAGEMENT?

"Much has been said of late about a Federal Health Department. The 'Notes' has taken little part in the discussion, but it has been busy putting two and two together. Having maintained a conservative attitude, and having been engaged in public health work for many years, and having neither friends to reward nor enemies to punish, and courting no favor, nor fearing criticism within or without the ranks, it may be able to deliver a calm judgment in the premises.

"It was proposed by the advocates for a Public Health Department that all the existing public health agencies should be assembled into one department, with a secretary in the President's Cabinet, which procedure, it is alleged, will prevent duplication of work, make the medical officer in charge independent of a superior, and add to the dignity of the service.

"To the practical legislator there are some well-nigh insurmountable obstacles in the way of a public health department. There is an inherent objection by Congress—representatives of the people—to multiplying cabinet officers, and the necessity must become urgent before it will be seriously considered. And even then the advantages must be poised against the disadvantages; the proposed method against the present one; and then, when the possibilities of the existing method are subtracted from the possibilities of the proposed, it is only what is left that the practical legislator will consider of any vital importance.

"When that subtraction is made there isn't much left, is there? A department would have no more power than a bureau to enter a State. The Department of Agriculture, for instance, in the control of diseases of domestic animals, can

*Note—Argument submitted by Dr. Hiram Byrd, then Assistant State Health Officer, now residing at Bradenton, Fla.

only exercise independent jurisdiction along the State lines and in an interstate authority; so can the Bureau of Public Health and Marine Hospital Service in the control of human diseases. Indeed, it is a universally recognized principle of our government that the police powers are reserved to the State and cannot be encroached upon by the Federal Government, and that the sanitation of a State is a part of the policing of it.

"An assembling of the several public health agencies simply means transferring certain bureaus, and parts of bureaus, from one department to another: the Bureau of Vital Statistics from the Department of Commerce and Labor to the Department of Public Health; a part of the Bureau of Animal Industry and of the Bureau of Chemistry from the Agricultural Department to the Department of Public Health, and the Bureau of U. S. P. H. and M. H. Service from the Treasury Department to the Department of Public Health.

"This assembling of the several public health agencies into one department is impossible, for the Army Medical Service will still be the Army Medical Service and will be unaffected by such an exchange; and the Navy Medical Service will still be the Navy Medical Service and will be unaffected by it. The actual assembling will be the transferring of the Bureau of Vital Statistics from the Department of Commerce and Labor to the proposed Department of Health; and the similar transfer of parts of the Bureau of Animal Industry and of the Bureau of Chemistry to the proposed Department of Public Health; and something done—Lord knows what—to the Bureau of Public Health and Marine Hospital Service, wherein it will be transferred from the Treasury Department to the proposed Department of Health and made over into a department with a new head and whatever else the fortunes of politics might make.

"It has not been shown just what advantages would be derived from such transfers of bureaus. Nor, for that matter, has it been shown that any advantage would be derived therefrom. For example, what advantage would be derived from transferring the Bureau of Vital Statistics from one department to another, where it would still be a bureau? Or a part of the Bureau of Animal Industry? Or a part of the Bureau of Chemistry? Or the Bureau of P. H. and M. H. Service, where it would be absorbed, more or less disorganized, and reorganized by, if not a less capable director, at least one that is less familiar with the needs of the service? The practical legislator must be shown the advantages of such changes before he will seriously consider them.

"The second argument advanced by the advocates of a department, is that it will prevent a duplication of service. The practical legislator will say that sounds good, but he will want to know where there is a duplication. That the Bureau of Animal Industry has a laboratory, and that the Marine Hospital Service has a laboratory does not say that there is a duplication of service. Indeed, such bureaus have several laboratories, but it has not come to our notice that any two of them are doing the same work. The legislator will need to be shown; he will not take it on faith.

"That a department will lend an added dignity to the Public Health Service no one will deny, but that dignity will make for better health will also have to be shown. And until the advocates of the measure can show to the satisfaction of Congress that there will be some distinct gain in efficiency by transferring these several bureaus from one department to another; and that such transfer will make for economy by preventing a duplication of work; and that the added dignity of a department over a bureau will make for efficient service; one or all of these; they are going to have an uphill pull trying to convince Congress of the wisdom of tearing down an efficient system already in vogue and building up an untried one in its place.

"And the weakness of the claimants for a department will be all the more apparent when we come to consider some fundamental objections to it, all of which have got to be more neutralized by the advantages of the proposed system before the legislator can show even a reasonable excuse for the change.

"One of the fundamental objections is found in the fact that it is not in keeping with our principles of government to limit the President in the selection of the members of his Cabinet. He is, therefore, free to choose for the secretary of the proposed department whomever he sees fit. And with the hundred and one quasi-medical medical creeds extant in the United States, all enjoying pretty much the same liberties that the hundred and one religious creeds enjoy, it is a matter of considerable chance which creed

might enjoy the distinction of being represented in the Cabinet. For it is to be remembered that we are legislating not for the present generation alone, but for generations yet unborn.

"This pitfall can't be escaped simply by providing that the Assistant Secretary of the Department be a medical man, etc., for that defeats the original purpose of the act, which is to get a medical man in the Cabinet, so that he won't have to go through a superior officer to make recommendations. Or to say it another way, as it stands now, the medical man at the head of the public health bureau has a superior officer, the Secretary of the Treasury, between him and the Cabinet. As it would stand then, the medical man (known in this instance as the Assistant) would still have a superior officer, the Secretary of Health, between him and the Cabinet. A veritable case of 'Tweedledum and Tweedledee'.

"There is still another obstacle connected with these hundred and one several cults, 'isms', schisms and creeds. It might be illustrated by the capital situation in Florida. The capital is located at Tallahassee; Jacksonville, Gainesville, St. Augustine, Ocala, Pensacola and, probably, a hundred other places would like to have it. Every little while one makes a pull for it. Whenever it does, it doesn't get the support of any of the other aspirants, because they all see their ultimate hope vanish with the removal from where it is. And this explains the existence of the organization known as the Medical Freedom League—an organization made up of quasi-medical creeds, cults, 'isms', schisms, all to oppose the creation of a department of public health.

"Now, it is perfectly feasible to have a department of health in Cuba. There the sciences are all under the University of Havana. Nothing scientific is recognized that does not have the stamp of approval of the University. This does away with the complication arising from a multiplicity of cults, and withal is an admirable system. But Cuba, it is to be remembered, is in a class to itself in public health affairs. A combination of circumstances not to be found elsewhere in a republican form of government has resulted in a public health department, the efficiency of which is just as rare. This combination, among other things, makes a department both feasible and necessary. But in Europe it is quite different. The two leading monarchical and the two leading republican governments have the public health organization subordinated to some other department of the government, just as it is in the United States at present. To be perfectly frank, it is not apparent to us just wherein a department would have any higher coefficient of efficiency than a bureau. A department would have no more power to enter a State than a bureau has; could do no more to prevent the introduction of epidemic disease from abroad than a bureau can; could do no more to control or eradicate epidemic disease, once it gets established in the country, than a bureau can; could institute no new line of research that a bureau can't; could command no better administrative ability than a bureau can. In a word, a department could no more possess a greater authority, no higher scientific attainments, and no better administrative ability than a bureau, and

'All the rest is leather or prunella'.

"One of the arguments that has been advanced in favor of a department is it ought to be a model for the State public health departments. What States, pray? Certainly not those that already have efficient organizations, for they need no models. They are capable of discerning their own needs without having a pattern made at Washington. They would not modify their own organizations to conform to a Federal pattern. And this, by the way, includes a great majority of the States at the present time. Public sanitation is developing rapidly in all parts of the country—as rapidly as local conditions will allow—and a department in Washington, even if it were better than a bureau, would not advance the cause.

"It would seem rather presumptuous on the part of the Federal government to create a department for a reason of that kind, for it would seem to imply that the States are not capable of self-government, and while that may be true, it would not be nice for the Federal government to say so.

"If the advocates of the measure feel that they need a model for their own particular States, there are plenty of State organizations that would serve as excellent models, better, in fact, than a Federal department would serve as a State model.

"For these and other reasons, we repeat that we fail to see the advantage to be derived from a department over a bureau, even sufficient to offset the disadvantages of multiplying cabinet

offices, tearing down an efficient bureau of public health and erecting in its stead a more elaborate, untried and, possibly, top-heavy scheme. The better plan would be for Congress to enlarge the functions of the bureau as the needs of the service demand. This would do all that can be done for the public health, and would have all the advantages of the department without the fuss and feathers."

It will be understood and appreciated from reading the above argument, that the present Constitution of the United States, without amendment, would not permit a complete surrender by the States in their inherent right of self-management in police control of life and health, and, therefore, a National Health Department would have no more authority to function within the boundary lines of a State, without consent of the State, than then existed under the administration of the Bureau of Public Health operating under the direction of the Secretary of the Treasury. Cooperation of the States in management of health affairs was all that could be effected under any Department of Public Health, and that cooperation has not been withheld under the existing conditions.

As far as can be learned, and as was mentioned, the nations of the world, those of Europe and others, with the exception of Cuba, controlled their health and sanitary activities as one detail under a branch of government such as State or Treasury.

In the article quoted, special attention was called to the situation in Cuba as being peculiar, and admitting of a separate department. The medical department of the University of Havana controls the practice of medicine on the Island of Cuba, and therefore there are no "cults" of so-called medicine to deal with or to rise up in opposition to orthodox teachings in sanitary science. For instance, in the United States, with its thousands of supposed "healers" and individuals setting themselves up as dispensers of "cures", a Department of Health, supervised by an appointee of the President as a Cabinet Officer, may be in thorough unison with the views of the President, who could easily belong to a "cult" of the "healer" type. Such an appointee would work great confusion and hindrance in administrating efficiently the affairs of the National Organization, and with no little hazard to life and health during his incumbency.

The possibility of such a contingency arising quickly became apparent to those who gave thought to the subject, and after failure to have the Senate Committee favorably consider the proposition, the demand for a Department of Health passed into the discard of unreasonable suggestions and probably has been forgotten. Then it was that the advocates of extended betterment of the public health of the country made concerted efforts upon Congress to impress that thoughtful body of men with a necessity for giving the Public Health Service every logical authority that might be needed in exercising effective control over prevention of disease epidemics into the country from outside sources, as well as to adopt such measures in the interest of improved health conditions in the domestic territory of our own Republic as might be wise and feasible.

Whether the part taken by the Florida State Board of Health in directing public sentiment in opposing an impracticable plan because of our form of government, for the printed opinions were broadcast through the mail, and advocating, instead, improvement of the Public Health Service by added facilities through increased appropriations, accomplished anything or not, the fact remains that not long after the failure of the Department of Health proposition in Congress, a resolution was introduced at an annual meeting of the State and Provincial Boards of Health at Washington in 1910, recommending a change of name for the Bureau to the "Public Health Service of the United States", and providing for different activities by designated titles, in this proposed new bureau, Congressional action was taken and the present Public Health Bureau was completely reorganized.

Another of the happenings connected with the health work in Florida during the past fifty years or more, which was overlooked when the first edition of "Health Scraps" was written, was the succor to indigent crippled children of Florida offered by the State Board of Health about 1910. No more beneficient effort could have been conceived, and the surprising results attained justify fully both the effort and expense.

About the year 1906, a young medical man, with his little family, came to Jacksonville, Florida, from the Windy City of the Great Lakes—Chicago. He made his home in Jacksonville, was well-received by the medical profession of

that city, and was successful in his specialty of surgery. One day, when visiting the Executive Office of the State Board of Health on another errand, Dr. Raymond C. Turck, for he it is to whom this incident refers, suggested during the conversation the possibility and feasibility of establishing an orthopœdic ward for indigent crippled children of the State in some of the hospitals of Jacksonville. Dr. Turck offered his services gratuitously if the State Board of Health would provide the ward, with maintenance of nursing and equipment. This offer was gratefully considered by the Executive Officer of the Board, and when presented to the members of the State Board of Health, was likewise approved of and accepted.

A suitable ward with nurses and equipment, all of which was to be paid for from the State Board of Health fund, was secured at St. Luke's Hospital at Jacksonville and immediately received the State's afflicted patients. What this orthopœdic help gave to the indigent crippled children of the State can be learned, better than any description here could recite, if the reports of the State Board of Health to the public of Florida, in the years alluded to, are read and studied. Some of the most marvelous cures were effected, from distorted joints, facial contortions and bodies which seemed impossible to make useful, the skill of Dr. Turck transformed into normal little citizens, and all were pleasing in appearance after having undergone these corrective operations. But this transformation was not done in a day or a week, or even a month, for in some instances it took months to bring about a coordination of bone and muscle, or to transform twisted feet, or to set aright obliquely directed eyes, that crooked paths might be made straight or distorted vision restored to a normal perspective.

Dr. Turck was director of this gratuitous humane work of which he was the originator, and which had been accepted by the State Board of Health from the year of its inception, to 1914, when, unfortunately for the State, the disturbance on the Mexican border in that year inspired Dr. Turck with the spirit of military service, and he became a surgeon of the Florida contingent which served during that episode, engaging in the campaign which was conducted along the Rio Grande that summer. Equally unfortunate in this respect, for Florida, was the occurrence of the World War immediately afterwards, Dr. Turck continuing his military career as a surgeon with the A.E.F. in France, where his record was brilliantly successful, as has been learned with pleasure by all of his former confreres—useful to our country in battle, as his professional surgical services were without equal in time of peace. Fortunately for the indigent crippled children of Florida, Dr. Turck had associated with him in his humane work, before he entered the Army Medical Service, Dr. J. Knox Simpson, also a surgeon of Jacksonville, so when the military fever fired the breast of Dr. Turck his mantle fell on the shoulders of Dr. Simpson who, skillful and likewise generous, gratuitously gave of his knowledge in unstinted time and work to the little afflicted ones of Florida's commonwealth. The writer has pleasant and grateful recollections of the services of these two professional brothers, and thanks them as only a Floridian could and should, for their generous donation of surgical knowledge, skill and devotion to the cause.

The annual reports of the State Board of Health during the years mentioned contain photographs of wonderful cures effected by these gentlemen, the recitals accompanying the photographs give graphic descriptions of deformities when entering the hospital as well as illustrations of curative treatment which followed. Floridians of twenty years ago, attendants at St. Luke's, well remember the appearance of these waifs of the State, with their distorted bodies, disfigured faces and careworn countenances, as they came from home to enter a new environment among strangers, and the sympathy their presence elicited. They may also recall the marked change in physical appearance and happy contented expression of countenance when, after a few months, they returned physically fit to engage in the battle of life, sound in limb and mind. Floridians of today should honor these men with an honor only to be compared and bestowed by Him who said: "Let the little children come unto me, for inasmuch as ye have done it to one of the least of these, my brethren, ye have done it to me". There are many such humane and compassionate medical men in Florida, but whose modest and retiring methods of performing charitable work and God-given help hides their deeds.

An incident connected with the "Crippled Children's Relief" movement in Florida is interesting history. The Legislative session of

1911 was in full swing, and Governor Albert W. Gilchrist was as active and peppy as a new governor usually is. The State Health Officer chanced to drop into the Governor's office one morning to pay his respects, and found him in a moody, distressed frame of mind. In his well-meaning philantrophy, the Governor had drawn inspiration from the work which the State Board of Health was actively engaged in carrying on for the indigent crippled children of Florida, and had drafted a bill providing for a hospital for Crippled Children of the State. It had been introduced as an administrative measure, but—and here the blow fell—the Judiciary Committee of the Senate had turned a deaf ear to the appeal and it was rejected in Committee and reported back to the Senate adversely.

It was then that the Governor sought assistance from the State Board of Health. There was no doubt but that the object of the act as framed by the Governor was a most worthy one, but, like all measures drawn up by persons unfamiliar with the purpose or details of management, it contained impractical provisions which could not be financially effected at that stage of the State's development. The State Health Officer and the Governor carefully canvassed the measure and eliminated conflicting provisions. The bill thus corrected was taken to the Chairman of the Judiciary Committee of the Senate by the State Health Officer, and explained for another consideration. After a consultation with his confreres of the Committee they accepted the amended bill and reported it back favorably—thus the Governor's pet measure was saved through the instrumentality of the Executive of the State Board of Health happening in at a timely moment and by his familiarity with cogent reasons for its enactment. This incident may be said to teach an important lesson in law-seeking authority: Always be certain of what is needed or even thought desirable before asking for it. The measure, after its redraft by the State Health Officer, who revised it to meet actual or existing conditions, was recalled for consideration and passed. It is now one of the beneficiary provisions of the State Board of Health and, as finally enacted, it read:

"HOSPITAL FOR INDIGENT CRIPPLED CHILDREN

"An Act to authorize and Direct the State Board of Health to Establish a Hospital for the Treatment of Indigent Crippled Children and to Provide An Appropriation Therefor.

"Be it enacted by the Legislature of the State of Florida:

"SECTION 1. That the State Board of Health be, and is hereby authorized and directed to establish at some suitable and convenient location in this state a hospital for the treatment of indigent crippled children of this State. In such hospital indigent crippled children of this State shall be received and treated free of charge.

"SECTION 2. That for the purpose of Section 1 hereof the State Board of Health is hereby authorized to purchase a plot of ground with building already erected in its discretion. For such purchase and for the purchase of suitable instruments, apparatus, furniture, fixtures, and other articles necessary for such an institution, the sum of twenty thousand dollars, or so much thereof as may be found necessary, is hereby appropriated, payable from the State Board of Health fund.

"SECTION 3. That for the purpose of maintaining the hospital herein provided for, and of employing such physicians and attendants as are requisite for the amount of the hospital, the sum of ten thousand dollars, or so much thereof as may be necessary, is hereby appropriated, annually for the two years beginning July 1st, 1911, payable from the State Board of Health Fund. Provided that until the number of indigent crippled children, citizens of the State of Florida, shall be sufficient in number to warrant the State Board of Health to erect and maintain an institution of this character and nature, that the State Board of Health is authorized to arrange with any sanitarium or hospital in Florida to care for and treat the indigent crippled and deformed children of the State and to pay for such treatment out of the funds of the State Board of Health, not in excess of the amount appropriated by this Act.

"SECTION 4. This Act shall take effect July 1st, 1911.

"Approved May 30th, 1911."

Before closing this chapter of "recollections" it is recalled that very little was said in "Memory's Scrap History", of why second attacks of yellow fever so very, very seldom occurred or were noticed. As a matter of fact, the writer, in his large and long experience with yellow fever epidemics, has never come across such a recurrence. A laity friend lately asked this question and further inquired why this matter was not touched upon extendedly in the

pamphlet, "Looking Backward over Fifty Years of Health Work in Florida", this feature of yellow fever not having been even casually mentioned. There is nothing to be said or explained, except it is well known that certain zymotic diseases confer immunity to second attacks.

During the epidemic of yellow fever in Key West in 1887, the Monroe County Board of Health observed that adults of many years' residence in Key West did not contract yellow fever, no matter how virulent the disease prevailed. Then it was noticed also that children born after a previous epidemic contracted the disease in succeeding epidemics, suffering only slightly—some scarcely going to bed, merely lounging around as if only mildly indisposed—as a general rule, children were but very lightly sick, and fatalities totalled less than 2% of total juvenile cases; in after years they proved immune to the disease whenever exposed to epidemics of yellow fever. Having experienced an attack in childhood, however light, conferred an after immunity to yellow fever. The matter was of sufficient interest to cause a discussion of this feature of yellow fever with Dr. John Guiteras, a Surgeon of the U. S. Marine Hospital Service, then stationed at Key West, afterwards professor in the University of Havana, Cuba. He, too, had studied this interesting phaze of the disease, and had arrived at the same conclusion as that reached by the Monroe County Board of Health —that one attack of yellow fever conferred an immunity against subsequent exposures, and on the strength of this belief, the county board of health advised parents to record in their family Bibles the date of any "fever" occurring among their children when yellow fever was also prevailing in the city. Professor Guiteras, now deceased, communicated this opinion of immunization to second attacks, which a well-authenticated previous attack conferred, especially in children, to his colleagues in Havana, when he was associated with the University of Havana, for Cuban physicians had an idea that immunity to yellow fever was always acquired through a racial residence in Cuba.

It is not assuming too much when it is said that the Monroe County Board of Health, through a thorough study of the subject of immunity to diseases by previous attacks, was convinced of the important fact that yellow fever came within the purview of scientific quarantine management, and permitted commercial intercourse and passenger travel between Key West and Havana during the summer season, to those passengers who could present indisputable proof of immunity to yellow fever. Thus came, as has been mentioned, the Plant Steamship Line to be established between Florida and Cuba in 1887, and later the merger with the East Coast Steamship Line, now known as the P. & O. Steamship Company, from Florida ports to Havana.

It has always been said, and bears repeating, that it was Florida's Health Board which established an international commercial industry during the summer months between Cuba and Florida (under sanitary conditions) that has proven of such an immense factor and financial benefit to the commonwealth of Florida. A trade between the two countries sprung up which is today valued in many millions of dollars a year in the matter of exports and imports, and the facility of handling in unbroken packages in transit from this country, the bulk of this great commerce has largely contributed to the rapidity and safety of transportation in such an efficient manner as to make for an annually increasing trade between these two countries.

Typifying the unreliability of memory—which has been so frequently alluded to in this writing —in attempting to chronicle salient events in the health history of the State for the past half century, is the failure to mention an innovation in health activities inaugurated in the latter part of the past century, when a Veterinary Department was added to the State Board of Health as one of its important enterprises. This event occurred on October 9th, 1911, shortly after the State Agricultural College, located at Lake City, had been absorbed or amalgamated into the general educational system which the Legislature had provided for when it abolished the state-wide system of schools supported by legislative appropriations. These schools, which were located in various sections of Florida, were but meagerly fulfilling educational purposes, and were accordingly abolished. Dr. Charles W. Dawson was at that time a professor in the Lake City institution, occupying a chair in the Division of Animal Industry. When the State Board of Health determined to include the care of domestic animals within its scope of hygienic work, Dr. Dawson was offered the Directorship of this important division. A graduate from the Department of Regular Medicine at Johns Hopkins University, and also a graduate of a Veterinary College of

Medicine, Dr. Dawson was thoroughly equipped to supervise this work. It is, indeed, a pleasure to the writer to testify concerning the faithful and painstaking manner in which Dr. Dawson attended to the duties of his office, which he held until 1917, when he resigned. He remained in Jacksonville for several years after severing his connection with the State Board of Health, but eventually went West, where he is now residing, being now engaged, so the information comes, in the manufacture of serum used in the treatment of diseases common to lower animals.

Hog cholera prevailed extensively at the time of Dr. Dawson's connection with the State Board of Health, and many valuable herds throughout the State were threatened with this dread disease. It was due to his study and investigations of cholera that the "buzzard" became identified as a potent carrier of the germ, transmitting the disease, through his filthy habit of eating diseased carcasses, vomiting it up and leaving it to be re-eaten by roaming swine. Repulsive as it is to write this statement, it is the true cause of cholera epidemics, and useful knowledge to those interested in Animal Husbandry. Thus the State Board of Health was able to disseminate useful information to owners of swine, preventing destruction to a valuable industry in certain sections of the State.

One of the outstanding achievements of Dr. Dawson's career as Director of the Veterinary Department of the State Board of Health was the introduction of the Pasteur method of hydrophobia prevention, which he succeeded in bringing into general acceptance and practice. This treatment nullifies the effects of a bite from rabid animals, and serum can now be procured, at short notice, from biologic institutes to be administered to patients by local physicians, whereas, at that time, victims of maddened animals had to be taken to a Pasteur Institute in some large city for treatment. Under his administration it was arranged that this serum could be mailed out daily to doctors in need of it, all applications being made through the State Board of Health, who even went so far as to defray the expense of the treatment to indigents who could not afford to pay for it; in this manner, efficient protection against this awful disease was provided to every individual in the State. Only to those who have distressingly witnessed the painfully agonizing convulsions of a patient, mentally conscious while in its throes, is it possible to realize or appreciate the wonderful preventive power that this discovery of Pasteur has effected against hydrophobia. As science has progressed, the number of injections has been decreased by an added potency of the serum at each injection, and the number of days necessary to complete the preventive treatment accordingly lessened. One or two instances have occurred where treatment was refused, the person bitten having claimed that it was unnecessary—and a horrible death has followed; similar fates have happened to those who delayed too long to make the injections effective.

Dr. Dawson was devoted to his dumb friends, as he termed his patients of the lower animal kingdom; when asked why he had deserted the profession of regular therapeutic medicine and abandoned the practice of that higher calling to engage in veterinary work, he replied, "you see, doctor, when I treat these 'dumb friends' of mine, their mouths are closed against any complaints of odious drugs or bitter mixtures; they take what I give them without audible comment, or in questioning me as to 'what am I giving', and one thousand and one other questions regarding their probable element of sickness which it is unnecessary to answer. Yes," he concluded, "it is a much more satisfactory practice than regular medicine"—and probably Dr. Dawson was right, since it is a fact that dumb brutes are universally more grateful than we articulate humans and lick lovingly the hand that succors them.

The inauguration of a Veterinary Division in the State Board of Health's diversified activities proved to be of immense financial advantage to the people of Florida. The stigma of "tick-ridden cattle," which had been attached to the herd and stock-raising industry of this State, was removed, as ticks were removed, and cattle improved, enabling stockmen of Florida to meet the persistent and insistant demand for better dairy herds, beef-cattle and hides free of tick bites, which would obtain prices comparable with those of other states. Dipping vats were established, being formed of concrete-lined excavations with a depth sufficient to assure proper treatment of tick-infested cattle. An arsenical germicidal solution was used, and through this vat the cattle were driven, immersed neck-deep in the solution, which caused the ticks to drop off immediately. Treatment of tick-ridden cattle extended over a period of six weeks, with a dip

in the vat every two weeks, which was sufficient to produce freedom from these parasites.

In this work Dr. Dawson rendered valuable assistance by his writings, talks at Stock Meetings and constant urging of the cattlemen of the State to rid their cattle of ticks, which, as he said, drained the animals' strength, reduced the price of meat as a food commodity, as well as lessened the quality and quantity of milk in the dairy herds. The "Dipping Vat" construction was pushed to the front very rapidly, and although stubborn opposition was encountered, and still prevails in some sections of the State, on the ground that cattle are poisoned and die as a consequence of this "dipping process", yet not many years, and only a few months in some instances, were required to sufficiently demonstrate the soundness of his teaching and advice. Dipping Vats were built in different parts of the State, following the close of 1911, and not only the dairy herds, but meat-cattle as well, soon showed marked improvement, the former in weight and milk production, the latter in quality and quantity of flesh. The Counties of Palm Beach, Broward and Dade accepted the teachings of the State Board of Health, and after obtaining a "clearance" of "no ticks" from both the State and National Agricultural Department, petitioned to be declared "free of ticks". They also asked permission to quarantine against shipments of cattle into their territory unless they were tick-free, which was granted. Through the power to issue such restrictions against tick-infested animals they protected their territory from this parasite.

It is believed that Monroe County, at Key West, was the first in the southern part of the State to construct a "dipping vat" for the destruction of cattle ticks. Mr. Roland Adams, who operated a dairy, was the pioneer of this betterment, and has since been heard to remark that his herd of cattle increased in weight and milk production fully fifty per centum over what had been their former condition. The State Sanitary Live-Stock Association has been of indisputable service to Florida by its instruction to Live-Stock owners in the care of their herds and in carefully guarding the industry from contamination in a protective quarantine rigidly enforced against admission of cattle not properly certified to.

The haze of forgetfulness which accompanies advancing age is oftentimes annoying when trying to recall important occurrences from a mist of indistinct events which bear particularly upon happenings relating to certain developments taking place in the State; important when connected with an improvement to the life of either human or animal. Therefore, as has been so often mentioned in this monograph, with no records at the elbow, an appeal was made to the State Veterinarian, Dr. J. V. Knapp, for corroboration of such statements as memory was decidedly uncertain about. The writer is reminded by an extract from Dr. Knapp's letter, which follows, that Senator Barber of Macclenny, Clay County, was an enthusiast on the subject of "tick-eradication" of cattle, and built the first Dipping Vat.

Dr. Knapp's letter served to pleasurably recall the day when the "vat" was first operated, the gathering of citizens from far and near to see the running of the cattle through the solution in the vat, and, subsequently, the interest with which the result was watched. It is needless to state that those who witnessed the procedure then, and the benefits resulting therefrom, were thoroughly convinced of the monetary advantage which would and did follow in the weight of the cattle, and especially in the production of quantity and quality of milk from dairy herds.

Dr. Knapp has answered certain inquiries very interestingly, and his letter, with his permission, is incorporated in this narrative with the appreciative thanks of the writer.

"Florida State Live-Stock Sanitary Board
"Tallahassee, May 24th, 1926.

"Dr. Joseph Y. Porter,
Key West,
Florida.

"My dear Doctor Porter:

"Our records show that the first dipping vat constructed in Florida was built by Mr. C. F. Barber of Macclenny, Florida, and completed February 22nd, 1913. At the present time there are over two thousand concrete dipping vats in Florida, ranging in numbers from one to over one hundred in the various counties.

"In the spring of 1915, during your tenure of office as State Health Officer, said office, cooperating with the counties of Dade, Broward and Monroe, requested the United States Bureau of Animal Industry to send a representative to that area for the purpose of conducting systematic tick eradication work. It happened that the writer was the person designated by the federal

department and stationed in Miami the first of April, 1915. There was one vat in operation in Dade County at that time, which was located on the Mrs. Joe Scales place, ten miles west of Miami, on 12th Street. Six other vats were built that year in Dade County and three in Broward County.

"Shortly after arriving in Miami, I was designated to make a survey of Monroe County and determine the character of the county, number of cattle in it and what steps would be necessary to inaugurate tick eradication there. I found, upon investigation, that all the cattle in Monroe County were confined to the Island of Key West and numbered approximately seventy head.

"One vat was built on the Island east of town, somewhere in the neighborhood of the old fort beyond Casa Marina, which was at that time used as a grazing ground. Ticks were eradicated from this area and the same released from quarantine in 1916. This area, at that time, consisted of that part of Palm Beach County lying south and west of the Hillsborough Canal, all of Broward, all of Dade and all of Monroe County. As you will probably recall, all of this work of tick eradication, above referred to, was accomplished without State law or any compulsory requirement on the part of the State or counties. In 1917, Florida Legislature passed the first Act providing for and creating the State Live-Stock Sanitary Board. Following the enactment of this law, which provided for tick eradication by vote of the people in the several counties, the work was taken up in Lake and Orange Counties and was completed and released from quarantine in 1918. These counties became reinfested the same year and were placed back in quarantine. Other counties, Osceola, Seminole, Duval, Jackson, Washington and Escambia, all attempted to conduct tick eradication work under the provisions of the 1917 and 1919 Acts, both of which provided for the local option feature and none of which ever eliminated the tick or were released from federal quarantine. In 1923, a State-wide law was enacted, creating the present State Board and providing for the conduct of tick eradication by State appropriation. Since that time, Palm Beach, Martin, Gadsden, Liberty, Jackson, Calhoun, Gulf, Washington, Bay, and that part of Holmes County east of the Choctawatchee River, and that part of Franklin County west of the Apalachicola River have accomplished the work of tick eradication and have been released from quarantine. The Board is now conducting systematic tick eradication work in Walton, Okaloosa, Santa Rosa and Escambia counties and that part of Holmes County west of the Choctawhatchee River.

"Very respectfully,

"J. V. KNAPP,
"State Veterinarian."

From the first year of its inception in 1889, to June, 1917, when the writer retired from the position of Executive Officer, the State Board of Health received an annual report from the President and the State Health Officer, covering every activity engineered during that time, and containing an accurate account of expenditures involved in its varied undertakings as well as interesting and instructive contributions from assistants in his office. In that history-making period, when medical men were engaged in effecting one of the most important discoveries of the age—that of fastening upon mosquitoes the responsibility of transmitting yellow fever—the compilation of these reports were concerned chiefly with recording these events, and having been written when many of these deeds were but just executed, contained authentic information both as to those discoveries and to the annual progress of the Board in matters of life preservation, all of which might come to be regarded in the light of ever-advancing time as historic stepping-stones in the upward trend of medicine.

These annual reports were compiled in book form by the State Health Officer during his incumbency, and were presented to the public with his compliments as a reliable record of the State Board of Health's activities for that period. Unquestionably, these volumes constituted an important reference to those interested in the achievements of health progress in Florida—a valuable library—and while not now of particular moment in a generation that has itself lived through these same happenings, in decades to come they might have been looked upon as authority for the fact that Florida made a gigantic forward stride in that day in its quest for improved health conditions. "The Land of Flowers", with its eleven hundred miles of seacoast, its proximity to the West Indies, Central and South Americas, and its lawful as well as clandestine commerce with its neighbor, Cuba, menaced daily by plagues and virulent diseases, was forced to fight an incessant war in the interests

of its health preservation. Thanks to the constant efforts of many and gallant men, who expended not only money but personal effort, often giving their lives in toll, in an unceasing attempt to banish the Spectre of Death from the threshold of Florida's seacoast, this State was made safe and sound for Floridians through the resulting strict quarantine regulations and lawful enforcement of health ordinances.

Probably no other state experienced as great a stress or as trying a time as did Florida in that decade. Like all who endure travail, to emerge with strengthened and uplifted spiritual qualities, Florida, too, passed through that tragic, fever-stricken era to come forth equipped with a surer knowledge of health values, a firmer determination to make its shores a citadel against whose defending strength the ranks of disease might battle ineffectually.

A rumor has come to the attention of the writer that many of these records which were then so painstakingly preserved in the library of the State Board of Health, as a true history of its health crusade for Florida, have since been in greater part disposed of or destroyed by someone of his successors in office, as having no especial value, and thereby constituting so much rubbish. This act is greatly deplored, since the sole aim of the Executive Officer, at that time, was to preserve these records against the time when Florida might come to be the acknowledged leader in health advancement during that period of national history when plagues, imported from foreign countries, were wont to take their toll of life in America, and its seacoast States were but just beginning to recognize the necessity for maritime quarantine control.

In answer to the repeated inquiry which was asked throughout the State, from time to time, as to "What is the State Board of Health Doing?" the State Health Officer authorized the issue of a bulletin titled "Florida Health Notes", which appeared for the first time in July of 1892. This bulletin was sent to every state board of health, Florida municipalities, doctors, and citizens who expressed a desire to receive it. It contained a resume of activities of the Board for each month, together with information and statistics on current health matters which were gleaned from every locality under the jurisdiction of that organization.

"Health Notes" was well received, and through its columns the people of Florida came to know much about its own progress in health matters. Not only were the accomplished deeds of the Board set down in black and white, but its aims and ideals were likewise published, so that when the auspicious moment for realization arrived, the citizenry of the State could not fail to cooperate through a lack of knowledge concerning the necessity or efficacy of such undertakings, and in so doing defeat measures destined to benefit the commonwealth. No longer was it necessary to await the annual report of the Board for information as to its varied enterprises and its actual accomplishments, for each month, with the advent of "Health Notes", all particulars of this nature were accurately and painstakingly reported. Today, this periodical has come to be recognized as a vital detail of the work of the State Board of Health, and is established as the standard of information for that body.

More could be written, and perhaps interestingly told if "Memory's Storehouse" could be more widely opened so that sequences hidden therein could be collectively narrated. When it is thought that everything of historical value has been told, there comes to mind other incidents of equal import. Musing in semi-siesta—"day-dreaming", if you will—upon winter's sunshiny, southern veranda, they pass in vivid review only to become hazy, vague memories with the awakening to realities; by the time the office is reached they have hastened into the realm of forgotten events and cannot be recalled. So, as the lawyer for the prosecution concludes his argument: "The State Rests"; these recollections close for awhile, anyway. If the clasp of "Memory-Scraps" is still open, and kind Providence permits, "Recollections of Medical Men in Florida, Whom the Writer Has Had the Good Fortune to Have Known in the Past Half Century", may be told in another chapter.

There are now 1 025 members in the Association. Each member is expected to send one news item each month and do his part to make the Journal interesting.

ADVANCEMENTS IN THE TREATMENT OF ATROPHIC RHINITIS WITH OZENA*

WALTER T. HOTCHKISS, M.D.,
Miami Beach.

We have chosen for our subject tonight a short discussion of the advancements which have been made in the treatment of atrophic rhinitis with ozena. This title is somewhat misleading, as these newer treatments are not truly recent (the most important having its inception about five or six years ago), but they have now reached that interesting stage when a sounder idea of the end results can be obtained.

We have all encountered these cases with their persistent, putrid odor; we have realized the crying need for relief for the victims of this disgusting affliction, but I think you will universally agree that formerly treatment only afforded a unsatisfactory degree of relief, which was usually of a very temporary nature. Any method, therefore, that promises a permanent cure or a real reduction in the amount of odor should be welcomed.

You are all so familiar with atrophic rhinitis that only a hasty review of the text-book picture will be necessary. You remember that in this condition there is an atrophy of the nasal mucosa which results in a desquamation of the epithelium and its replacement by a smooth, pale glistening membrane. The glands become obliterated, there is a relative increase in the submucous fibrous tissue and a marked arteritis-obliterans. The atrophy later extends to the bony framework and is especially noticeable in the inferior turbinate. This body often becomes so small as to be a mere nub on the lateral wall. One of the earliest locations of the process is in the olfactory portion of the nasal mucosa and is evidenced by a progressive loss in the sense of smell. The process may extend into the nasopharynx and even into the larynx and trachea. The loss of structure produced by the atrophy creates an enormous increase in breathing space. This observation assumes great importance when the surgical correction of the condition is considered.

The outstanding symptom is, of course, the frightful odor, and this assumes a major importance since these patients become social outcasts and are forced to lead a hideous existence. Social contacts are often impossible, and there develops a very introspective and morbid mental state. In pronounced cases great difficulty is experienced in earning a livelihood solely because of the terrific odor. The atrophic mucosa is covered by heavy, green, inspissated crusts which are underlayed by a muco-purulent discharge. The manual removal of these crusts often produces ulcers, septal perforations and a tendency to epistaxis. Fortunately, there develops a loss of the sense of smell, particularly for their own ozenic odor. These patients exhibit surprisingly little ill health and it is generally assumed that there is a minimum of toxic absorption from the condition.

A multitude of causes have been advanced, but even today there is no conclusive evidence of a lone causative factor. It occurs more often in girls than in men; it usually makes its appearance in the early teens and rarely begins after the twenty-fifth year. Although it is probably not a heriditary disease, it often occurs in several brothers and sisters in a family. It is not infectious, contagious, nor are tuberculosis or lues the causative agents.

A number of organisms have been described, among them the bacilli of Lowenberg, bacillus fœtidus and the cocobacillus. A diphtheroid organism is found in about 15% of the cases. The spirillum of Vincents is often present. However, none of these are generally accepted as the primary agent. It has been noted that in cases of injury to the trigeminal nerve, especially the sphenopalatine branch, a typical atrophy with some ozena may develop. This suggests a trophic factor. It has been contended that chronic nasal infections in childhood, especially in the posterior group of sinuses, is the exciting cause, but many cases are seen in which ozena develops in a nose absolutely free from previous nasal trouble.

At present we must be content with the explanation that ozena is probably produced by a combination of causes: infective, trophic and constitutional.

If the suggested causes are multitude the attempted forms of treatment are legion. We may almost say that therapeusis has been instituted from every conceivable angle. While sporadic cures and improvements have been reported, the great mass of patients derived little or no benefit. I have condensed the conservative forms of

*Read before the Dade County Medical Society, June 4, 1926.

treatment that have been used into three main groups with no attempt to mention all the different methods. First: All manner of nasal douches, antiseptics and deodorants. While in general these gave the most satisfactory results, the benefits were too temporary. I have known patients who found it necessary to irrigate with a strong deodorizing solution three times a day that they might be tolerated by their fellow men. Second: Nasal massage and stimulating treatments such as electro-therapy, intended to overcome the obliterating endarteritis. Third: Vaccines of many types were developed but none gave satisfactory results. Surgery was usually directed towards the sinuses on the assumption that sinus disease was the basis of the trouble. Considerable relief was sometimes obtained in those cases where the atrophy had invaded the sinuses and there was an accumulation of crusts, by establishing permanent drainage and increasing the accessibility of the sinuses for daily treatments. However, the original nasal atrophy remained unchanged. An example of the more radical surgery, which was resorted to in bad cases, was that in which Stenson's ducts from the parotid glands were transplanted into the antra. This produced a constant flow of saliva through the nose and was, in effect, a continual nasal irrigation. It needs no stretch of the imagination to realize the unsavory nature of the result.

From all this mass of earnest but generally ineffectual work, however, there have developed two main methods of attack which are proving clinically to be a real advance in the treatment of this condition.

It was finally noted that the secondary infection, for it is generally agreed that the infective component is secondary and not primary, found difficulty in growing in a media containing a fairly low percentage of sugar. From this has developed the so-called "glucose treatment" for ozena. This consists in first thoroughly removing the crusts by irrigation, or forceps if necessary. The nose is then packed completely with a syrupy solution of ordinary brown sugar. This is left in place about six hours and can be removed by the patient at the end of that time. He is instructed to use a daily saline nasal irrigation at home. In two days he returns and the "glucose pack" is again inserted, to be removed as before. Now, depending on the severity of the atrophy, he can be allowed to assume more and more of the treatment at home. At first this consists of the daily irrigation followed by the instillation of the sugar himself. This is accomplished by having the patient snuff up a pinch of ordinary brown sugar into each nostril. At first this produces some irritation but they soon become accustomed to it. In many cases an improvement will soon be noticed, and when the patient finds that he is free from odor throughout the day it is advisable to modify the treatment, using the irrigation and glucose every other day. In this way it is often possible to keep the patient in an acceptable condition and yet reduce the number of treatments to one or two a week. I have never seen a permanent cure by this method, but there have been some gratifying results which could not be obtained by any of the older methods.

There have various modifications of this method been devised. On the continent and in England other sugars are used (fluid honey, for example) and the results are much the same as ours.

You will find that this glucose treatment will handle cases that are intractable under the older methods and that many patients are made completely happy and are not bothered by the comparatively infrequent home treatments. On the other hand, occasionally we meet a case which at first would seem to offer good chances for cure (one with no excessive odor or crusting) which will not respond to the glucose or any other form of conservative treatment. For these cases, and also the more pronounced ozenas, we are forced to adopt a more radical procedure.

For these types of the disease we now have available a surgical measure far superior to anything we had to offer in the past. About six years ago Halle became convinced that improvement might be expected if the excessively wide breathing space, due to the atrophy of the lateral wall structures, could in some way be narrowed. This he did in the operation which bears his name. It is essentially a method of separating and fracturing the side walls of the nose inwards and holding them in their new position by allowing adhesions to form between them and the nasal septum. It is usually done under local anesthesia by nerve block. An incision is made through the nasal mucosa beginning just in front of the anterior end of the middle turbinate and extended vertically downward in front of the inferior turbinate to the floor of the nose. The

mucous membrane under the inferior turbinate and that of the floor of the nose is now elevated away from those bodies. By means of a chisel this vertical incision is now carried through the bone into the antrum, the bony incision being extended upwards as far as the roof of the antrum and downward to a point just below the anterior end of the inferior turbinate. From this point the chisel separates the lateral nasal wall in a horizontal direction back to the posterior wall of the antrum. We now have the lateral nasal wall hanging only by its attachment to the ethmoid area above and posteriorly. A strong blunt elevator is now introduced into the antrum through this opening and strong pressure applied to the remaining attachment of the lateral wall from the antral side until it is fractured into contact with the septum. The nasal mucosa of the lateral wall and of the septum, which has been brought into contact by this manipulation, is now scarified to promote the formation of adhesions.

The same steps are followed on the opposite side. The side walls are held in apposition to the septum either by packing both antra or by passing a mattress suture from one lateral wall to the other through the septum. After the adhesions have formed a pronounced diminution in the odor will be noticed and the crust formation will be replaced by a mucopurulent discharge. Examination will soon show that there is considerable tension on the adhesions and that the lateral walls are pulling away from the septum. This secondary widening provides an adequate breathing space and good intranasal drainage. The mucopurulent discharge persists for some time, but gradually diminishes, sometimes disappearing entirely, but often remaining in quantities sufficient to require an occasional irrigation. What is more important, however, is the fact that if adhesions hold, the prognosis for the disappearance of the odor is excellent.

Should the lateral wall tension become too great it will tear down the adhesions and require a secondary operation, which is a comparatively simple procedure. The most common complication is a tendency to abscess formation in the lachrymal sac due to interference with the lachrymal duct in the region of the inferior turbinate. In the cases I have encountered, simple incision and drainage have sufficed for permanent relief.

Our oldest cases are about three years post-operative. Of the twenty cases done, fourteen show a practically complete relief from odor, three are markedly improved, two are only partially relieved and one was a total failure, due to an inability to make the adhesions hold after repeated attempts. In the cases in which the odor entirely disappeared there was also an almost complete cessation of discharge, and in the others the amount of residual odor was proportionate to the amount of discharge. Halle has a large number of cases that are five years post-operative and reports that they remain improved.

One of the cases showed a very extensive involvement, the crusts being present in the pharynx, larynx and trachea as well as in the nose. Besides the pronounced odor there was a dry cough and a marked hoarseness. Following the Halle operation she made a very satisfactory recovery, the crusts, cough and hoarseness entirely disappearing, only a small amount of mucoid discharge being noticeable.

Lautenschlager has devised a modification whereby the work is done through an antral route, but the principle involved is the same. Pollack constricts the breathing space by implanting septal cartilage (taken from a previous sub-mucous operation) under the mucosa of the nasal floor and lateral wall. He has also used costal cartilage and reports good results. My experience has been entirely with the Halle operation, however.

I have been in the habit of trying out all new cases of atrophic rhinitis on the "glucose treatment" first, and if the patient obtains enough relief and is satisfied with the prospect of continuing a comparatively simple nasal toilet throughout their lives, the surgical measure is not considered. In this connection it is well to note that the treatment by glucose will begin to show results early in those cases where it is efficacious, so that a good opinion can be obtained after a very few weeks of observation. Should you become convinced that the desired progress is not being made, I believe that the Halle operation offers such a good prognosis that it should be very seriously considered.

CASE REPORT: SWALLOWED FOREIGN BODY, CAUSING MARKED EMPHYSEMA*

JOHN A. BEALS, M.D.,
Jacksonville.

The patient's history is short and tragic. He was a married man, age 41, in good health. On March 18th he swallowed a piece of oyster shell which he thought lodged in his throat. It is said by a member of his family who accompanied him that he consulted a doctor who used some kind of instrument in his throat; an esophageal probang, apparently. His pain and difficulty in swallowing were not benefited, but grew worse, and he began to experience considerable dyspnœa. The following day he came by train to Jacksonville, but his condition grew so critical that at one time the train crew waited while medical assistance was sought.

When first seen at the Riverside Hospital, twenty-four hours after swallowing the shell, he was in extremis, cyanotic, cold and almost pulseless, unconscious and gasping at rather lengthy intervals, the respiratory effort being peculiarly short and ineffectual. Subcutaneous emphysema was plainly seen and felt in tissues of neck, shoulders, upper arms and upper part of chest.

An X-ray film was exposed which failed to demonstrate the piece of shell, but showed a remarkable picture of emphysema, with evidence of patchy consolidation in both lungs. The mediastinal shadow is peculiarly broad.

The patient's evident respiratory obstruction and his dying condition demanded an emergency tracheotomy, which was done on the X-ray table by Drs. Knauer and Heggie. Palpation with finger in tracheotomy opening, discovered no obstruction; the vocal cords did not obstruct. However, immediately on opening the trachea the patient breathed more freely and continued to breathe with comparative ease through the tracheatomy tube. His pulse and color improved rapidly. Before leaving the table he apparently became partially conscious.

On the following day he was fully conscious, able to talk, but with difficulty on account of his tracheal tube. He appeared greatly improved, possibly destined to recover. However, physical examination gave evidence of a well-established pneumonia. His fever rose from 101 degrees to 104 degrees; pulse 112 to 140. An X-ray film showed an increase of the patchy consolidation, but a marked decrease in the width of the mediastinal shadow as well as in the subcutaneous emphysema.

The patient died on the night following his tracheatomy, the immediate cause of death being not clearly established.

This patient presents a rare, but tragic, consequence of a sharp foreign body lodged in the esophagus. It is evident that perforation occurred with communication, in some way, with the respiratory tract, hence the very marked subcutaneous emphysema. His pneumonia was probably due to aspiration of esophageal or regurgitated gastric contents. I believe the widened X-ray shadow of the mediastinum is due to emphysema in these tissues which would occur even though the perforation were high in the neck, as the superior mediastinum is continuous with the fascial compartment which incloses the trachea and esophagus. The fascial sheath which bounds this compartment is limited above by its attachment to the hyoid bone and below by its continuation with the pericardium. Within this compartment, therefore, the emphysema must have been greatest and its pressure have most depressed the function of important structures, such as the great vessels of the neck, the vagi, the sympathetic trunks and recurrent laryngeal nerves. As no obstruction could be felt upward through the tracheatomy opening, it is conceivable that the patient's relief from respiratory embarrassment came from opening this fascia as well as giving him a more direct respiratory passage.

*Presented before Riverside Hospital Staff, Jacksonville, Fla., May 25, 1926.

ERRATA

Through error, Doctor J. D. Love's discussion of Doctor William Ewing Sinclair's paper entitled "Eczema in Infancy and Childhood", read before the fifty-third annual meeting of the Florida Medical Association, held at Gainesville, was not returned to Doctor Love for correction, and for that reason some discrepancies have been called to the editor's attention. It is for this reason that we are publishing herewith the discussion as it appeared in the July issue of the Journal, followed by part of the discussion as corrected by Doctor Love. The Journal wishes to apologize to Doctor Love for the error.

Dr. J. D. Love, Jacksonville:

"I thoroughly agree with both Dr. Sinclair and Dr. Spengler as to the futility of the skin test in determining the cause of eczema. That has yet to be proven.

"As far as the breast-fed child is concerned, we practically never see a case of eczema, except in the case of a child that is being over-fed. It is the large, obese child, in most cases, that is suffering with eczema. I doubt very much if any one or more of the food elements play any important part in the production of this. That still remains to be proven.

"In the treatment of these eczemas of the breast-fed, probably the most efficacious measure is extending the interval between feeding and cutting down of the fluid intake, at the same time strengthening the skin by cleansing it with either olive oil or liquid albumin. As a matter of fact, it is my opinion that there is only one form of dry eczema in childhood, and that is the so-called exudative diathesis of children.

"We also have an eczema that is presumably caused by hyperthyroidism, which is closely related to the diathesis of children. Most of the so-called cases of exudative diathesis are simply that of dermatitis, caused by some local irritant. You can almost always diagnose a case of eczema due to hyperthyroidism from the fact that it exists mainly about the neck and chest, and is accompanied by certain cracking of the skin of the hands and palms. We have no real eczema of hands or feet. The so-called eczemas of this portion are due to a fungus and responds to almost any rational form of treatment. The so-called papular form of eczema about the feet and hands is either due to a luetic condition or scabies.

"I would emphasize the warning of Dr. Sinclair and Dr. Spengler concerning the extensive use of tar ointments. It is a very good general rule to follow not to apply tar ointment to more than one-fourth of the body at a time. Eczema in a baby is somewhat comparable to the vomiting of pregnancy—what would heal a case this month would have practically no effect on a case two or three months after that. Practically anything will cure certain cases of eczema and almost everything will fail in other cases."

Following is that part of the discussion which includes the discrepancies referred to:

In the treatment of eczemas of the breast-fed, probably the most efficacious measure is extending the interval between feedings and cutting down the fluid intake, at the same time cleansing the skin with either olive oil or liquid albolene. As a matter of fact, it is my opinion that there is only one form of true eczema in childhood, and that is the so-called exudative diathesis of Czerny.

We also have an eczema that is presumably caused by hypothyroidism, which is closely related to the diathesis of Czerny. Most of the so-called cases of exudative diathesis are simply that of dermatitis, caused by some local irritant. You can almost always diagnose a case of eczema due to hypothyroidism from the fact that it exists mainly about the neck and chest, and is accompanied by a certain cracking of the skin of the soles and palms.

STATE BOARD OF HEALTH NOTES

Did you read the July Health Notes, or are you in the same position two city officials were when they were asked why their city had such a high infant death rate?

That number contained an article on the care of biologics and stated what biologics were furnished by the State. It also asked for the cooperation of all physicians to the end that antitoxin be so kept as to produce the best results.

There was a summary of the examinations made in the laboratories and a list of the bilogics sent out; an article on Summer Diarrhea; one on the Care of the Pre-school Child; one on Oysters and one on Infant Mortality, and tables showing Number of Deaths Under One Year and Rates per 1000 Living Births by Counties and by Cities. These tables are worthy of careful study.

Dr. W. A. Claxton, who has been with the State Board of Health for a number of years, recently as medical officer on the lower East Coast, has resigned and been made Chief of the Division of Health, Department of Public Welfare, Miami.

There are in Florida forty-six members of the American Public Health Association. Of these, eleven are fellows.

All who are interested in public health work are eligible to membership, and all such will do well to join.

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THE ACCIDENTAL INSUFFLATION OF STEARATE OF ZINC

For quite some time reports have been coming in of cases of stearate of zinc poisoning, with a mortality rate of about 21%. In spite of this condition, manufacturers are still placing this product on the market, and these accidents continue.

There is, indeed, no doubt in my mind that many of the cases are not detected, and the child dies from an acute pneumonia, cause of pneumonia not known due to a lack of knowledge of the laity of the dangers of this drug and the failure of the physician to make a definite inquiry in regard to the use of stearate of zinc in the nursery.

This obstacle has occurred in my own practice, and on one occasion was not revealed until a small child mentioned the fact that the baby had a can of powder, was playing with it and some powder was poured in his face.

The committee from A. M. A., appointed to

report on this matter, found that stearate of zinc does not possess any material advantage over other dusting powders, and recommended that a safety cap be used on the containers. A safety cap does not appear to be a safe procedure, because the cost of product must be kept at or near the same price as other products, so the safety device would necessarily be ineffective. Few of the manufacturers are observing this precaution and continue to dispose of stearate of zinc in the old style container.

It seems there should be some means to prohibit the sale of this product, but while this is being done, the medical profession should not lose any opportunity to educate the public to the dangers of stearate of zinc. Used mildly, and as prescribed, it is apt to cause bronchitis and irritation of the upper air passages. Therefore, it should be branded as dangerous and condemned by the profession. The value of any dusting powder, as generally used, is of questionable value, and the sooner this is generally appreciated, will be seen a diminution of dermatitis and irritation of the upper air passages.

STATE NEWS ITEMS

RE-ORGANIZATION, TRI-COUNTY MEDICAL SOCIETY

The Tri-County Medical Society, embracing the counties of Indian River, Okeechobee and St. Lucie, was re-organized at Fort Pierce, Florida, on the evening of July 22, to include the newly formed County of Martin. The Society hereafter will be known as the Four-Counties Medical Society. The newly elected officers are: Dr. H. C. McDermid, of Okeechobee, President; Dr. J. W. Bishop, of Fort Pierce, Vice-President, and Dr. G. C. Hardie, of Fort Pierce, Secretary.

Dr. H. Mason Smith, of Tampa, President of the Florida State Medical Association, was present and delivered an excellent address in behalf of organized medicine. Particular stress was laid by him on the importance of the individual members working in harmony for the welfare of the Society, stating that no element of personal jealousy or animosity should be allowed to prevent everything being done for its betterment.

The Palm Beach County Medical Society was present in a body, and had the honor of acting as host at a dinner given by them at the New Fort Pierce Hotel, in honor of President Smith. Dr. R. O. Cooley, of West Palm Beach, President of the Society, acted as Toastmaster, introducing Dr. Smith in a most complimentary speech. Others speaking during the evening were: Dr. J. G. DuPuis, of Lemon City, Councilor from the 11th District; Dr. Leon Ashley Peek, of West Palm Beach, and Dr. John E. Hall, of West Palm Beach, Councilor from the 15th District. Dr. Peek gave an interesting talk relative to his recent tour of Europe, with the Inter-State Post Graduate Clinic Assemblies of North American Physicians in Europe, 1926. His description of the various countries and clinics visited was very attentively received and was instructive in character.

Other out-of-town visitors were: Drs. Page, of Cocoa, and Babcock, of Miami. Dr. Shaler A. Richardson, of Jacksonville, Secretary of the State Medical Association, was to have been present, but sent a telegram of regret.

The Four-Counties Medical Society should be one of the most active in the State, as it is composed of twenty-five of the leading physicians of Florida.

The success of the meeting was due, in a large measure, to the special efforts of Drs. Wm. J. Buck, George M. Dawson, W. E. Vanlandingham, of West Palm Beach, and G. C. Hardie, of Fort Pierce, former Secretary of the Tri-County Society.

The following program was rendered at the Quarterly Meeting of the Second District Medical Society, held at Tallahassee, Wednesday, July 14th, at three P. M.:

PROGRAM

1. Vasomotor Rhinitis—Dr. Hal M. Davison, Atlanta, Ga.
2. Congenital Pyloric Stenosis—Dr. J. C. Davis, Jr., Quincy, Fla.
 Discussion led by Dr. J. Q. Folmar, Chattahoochee, Fla., and Dr. J. K. Johnston, Tallahassee, Fla.
3. Pyelitis in Infancy and Childhood—Dr. J. B. Brinson, Jr., Monticello, Fla.
 Discussion led by Dr. J. B. Glover, Monticello, Fla., and Dr. W. C. McConnell, Chattahoochee, Fla.
4. Vincents Infection—Dr. J. C. Inman, Chattahoochee, Fla.
 Discussion led by Dr. J. Q. Folmar, Chatta-

hoochee, Fla., and Dr. O. G. Kendrick, Tallahassee, Fla.

5. Diarrheas of Infancy—Dr. F. Clifton Moor, Tallahassee, Fla.
 Discussion led by Dr. H. E. Palmer, Tallahassee, Fla., and Dr. L. L. Dozier, Tallahassee, Fla.
 Lake Bradford Frolic at 7 P. M. Picnic Supper at 8 P. M.

DIPLOMAS GIVEN TO FIFTEEN NURSES FROM ST. LUKE'S HOSPITAL, JACKSONVILLE

Fifteen nurses were graduated recently from the training school of St. Luke's Hospital, at the Woman's Club, with impressive ceremonies.

Those receiving diplomas were Miss Annie James Adams, Miss Eleanor Virginia Edwards, Miss Esther Fixter, Miss Ella Maye Hayes, Miss Mary Francis Highsmith, Miss Annie Belle Pullen, Miss Helen Pauline Edwards, Miss Willie O'Neta McEwen, Miss Willie Maybelle Meyer, Miss Ruby Estelle Lanz, Miss Mabel Carey Richards, Miss Ouida Bomralyn Durrance, Miss Jimmie Maue Fletcher, Miss Amy Imogene Parker, and Mrs. Hazel Isbell Waldo.

Dr. J. T. Sandlin, of Tampa, has just returned from New Orleans, La., where he attended the wedding of his niece.

The Orange General Hospital has let a contract for forty-five additional private rooms, to be completed this fall, giving them a capacity of one hundred fifty beds.

Dr. T. M. McDuffie, of Manatee, has returned from a ten-day visit at the Clinics of the University of Maryland.

Dr. R. M. Harris, of Miami, was married to Miss Leah Kraft, of Bloomington, Ill., on June 29, 1926.

Dr. L. C. Ingram, of Orlando, left recently for a two months' vacation.

Dr. C. H. Bryan, of Bradenton, returns soon from a two months' visit to Chicago and New York.

Dr. K. Y. Sinclair has removed his offices from Winter Park to the Clinic Building, Orlando, Florida.

The Medical Board of the Orange General Hospital elected the following officers for the coming year:

Dr. L. C. Ingram, President; Dr. C. D. Christ, Vice President; Dr. Meredith Mallory, Secretary and Treasurer.

Dr. F. D. Gray, of Orlando, was operated July 16th for acute appendicitis.

Dr. Sylvan McElroy, city physician of Orlando, has been sojourning in North Carolina.

DUVAL COUNTY MEDICAL SOCIETY REACHED THE 100% LIST SINCE THE LAST JOURNAL WAS PRINTED, HAVING THE STATE DUES OF ALL MEMBERS FULLY PAID. IN ADDITION TO THE ENTIRE MEMBERSHIP HAVING 100% OF STATE DUES PAID, THE DUVAL COUNTY MEDICAL SOCIETY HAS THE DISTINCTION OF HAVING THE GREATEST NUMBER OF PAID MEMBERS.

Dr. L. A. Peek, of West Palm Beach, has just returned from the International Post-Graduate Clinic, visiting hospitals and clinics in France, Germany, Belgium, Holland, Italy, Czecho-Slovakia and Switzerland. A most delightful and profitable trip is reported by Dr. Peek.

A number of citizens in Mandarin, Florida, are pleading for a physician to locate in their community. Doctor L. G. Haskell succeeded the late Doctor Kennedy, but has accepted the position of director of physical education for the University at Gainesville.

Doctor John A. Simmons, who has fully recovered his health after an illness of several months, wishes to announce the re-opening of his office at Room 408 Huntington Building, corner S. E. Second Avenue and First Street, Miami, Florida. Surgery and Gynecology.

Doctor P. M. Lewis, of Orlando, has returned to his office after an extended trip attending Eye, Ear, Nose and Throat Clinics in New York and Philadelphia.

Doctor G. H. Edwards, of Orlando, has returned from his trip north, where he attended his class re-union at Yale, and the Kiwanis Convention in Montreal.

Dr. W. N. Parkinson, of St. Augustine, has just returned from Philadelphia, where he ad-

dressed a reunion at his Alma Mater, Temple University Medical School.

The next examination given by the American Board of Otolaryngology will be held in Denver, Colorado, at the University Hospital, on Monday, September 13, 1926. Application should be made to the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Mo.

An addition is being built to the clinic building owned by Drs. McEwan and Edwards, of Orlando, increasing its facilities.

Dr. Franklyn Thorpe, of Tampa, is again at his office in the Lafayette Building after a successful operation at the Bayside Hospital for appendicitis.

On July 2nd, the Dade County Medical Society held its Annual Banquet at the Miami City Club, about sixty-five members attending. After the Banquet the program consisted of a paper on "Tetanus", followed by a discussion as to the various methods of treatment. Dr. Lustgarten demonstrated a case of "Common Iliac Trombosis as a Sequela of Chickenpox", a most unusual case—in fact, the only one recorded in the medical literature.

Dr. J. M. Davis, genial and efficient secretary of the 100% Manatee County Medical Society, has returned from a visit to friends, relatives, and maybe his sweetheart in South Carolina.

Dr. J. A. Pines, Roentgenologist for the Orlando Clinic, is in the North for a few months, taking a special course in his specialty.

Dr. Ferdinand A. Vogt, of Miami, was married to Miss Marion Wheeler, of Atlanta, Ga., on June 10, 1926.

Dr. M. M. Harrison, of Palmetto, left recently for a six weeks' course at the New York Post-Graduate School.

Dr. C. D. Christ, of Orlando, has returned from Maryland where he has a large farm.

The Dade County Medical Society has retained the services of the law firm of Price & Price to handle the legal aspect of certain cases of unlicensed practitioners and cultists of this community. The Health Department of Miami has handled a number of these cases and is showing hearty cooperation in ridding their community of those who do not wish to abide by law and order in our profession.

Dr. J. F. Mason, of Bradenton, leaves the 31st of August for a six weeks' course at the New York Polyclinic.

LEE COUNTY MEDICAL SOCIETY FORWARDED A CHECK TO THE BUSINESS OFFICE RECENTLY WHICH COVERED THE STATE DUES FOR THE LAST MEMBER IN ARREARS. THE LEE COUNTY MEDICAL SOCIETY IS, THEREFORE, SHOWN ON THE 100% LIST.

Dr. O. M. Knox, of St. Petersburg, Florida, died at Chateau Thierry, Friday, July 15, following a fractured skull as a result of an automobile accident. Doctor Knox and family were touring Europe when the accident occurred. Doctor Knox had just returned from Vienna where he had been taking special work in the treatment of the diseases of children.

Dr. Knox served as a medical officer in the navy during the World War, and for the greater part of the time was stationed at the Great Lakes naval station near Chicago. He had been a prominent physician in Chicago before the war and was one of the first to offer his services to the nation.

Dr. Knox was born in 1884, and as a boy lived in Texas. He was a graduate of the Illinois Medical school, Chicago, in the class of 1907. He came to St. Petersburg in the summer of 1919, after being mustered out of the navy at the close of the war. He had practiced there since that time. He was president of the Pinellas County Medical Society in 1924 and had a very extensive practice, specializing in children's diseases. His office was in the Power & Light building, where he was associated with Dr. Thomas R. Griffin.

Doctor Lauchlin M. Rozier, of West Palm Beach, was married to Miss Harriet S. Whitworth, of Palm Beach, on June 23rd.

Class of 1926 of the Bayside Hospital, Inc., Training School for Nurses, held their fourth annual commencement exercises Friday evening, May 21st, at eight o'clock, at the Tampa Yacht and Country Club.

Solos—Mr. H. Grady Daniels: (1) "A May Morning"—Denza; (2) "When the Heart is Young"—Dudley Buck.

Address—Dr. L. F. Carlton.

Solos—Miss Edmonia Elliot: (1) "Gypsy Love Song"—Victor Herbert; (2) "Night of Love"—B. DeSylva.

Presentation of Diplomas — Dr. John S. Helms, Pres. of Bayside Hospital.

The Nightingale Pledge—Graduating Class.

Presentation of School Pins—Miss Olive E. McMullen, R. N., Supt. of Nurses.

Major E. H. McRae, M.C., of Tampa, Florida National Guard, resigned on June 3, 1926. He had been in command of the Medical Detachment of the 116th Field Artillery since January, 1924. The vacancy was filled by Maj. George E. W. Hardy, M.C., of Tampa, who served as Captain under Major McRae during that time. The Medical Detachment will accompany the regiment on their annual Summer encampment at Camp Jackson, Columbia, S. C., from July 31st to August 15th. Following the encampment Major Hardy will spend two weeks visiting clinics in Baltimore.

Doctor G. F. Highsmith and wife, of Arcadia, are visiting in Georgia, North Carolina and Virginia. While in Virginia Doctor Highsmith plans to take some post-graduate work in Richmond.

Doctor William Erastus Sherman and Miss Mary Etta Folsom Abbott were married on Easter Sunday, the fourth of April, at Sebring, Florida. Doctor Sherman practices in Winter Haven and Miss Abbott was formerly health nurse in the Winter Haven District. Doctor and Mrs. Sherman recently left for Boston, where the doctor will spend two months doing post-graduate work at the Massachusetts General Hospital.

PALM BEACH COUNTY MEDICAL SOCIETY REACHES THE TOP! A GREAT DEAL OF ACTIVITY HAS BEEN NOTED AMONG THE MEMBERSHIP OF THE PALM BEACH COUNTY SOCIETY, NOT ONLY IN THEIR OWN TERRITORY, BUT REACHING OUT INTO NEIGHBORING SOCIETIES. A CHECK WAS RECEIVED RECENTLY COVERING THE DUES FOR THE LAST MEMBERS OF THE PALM BEACH SOCIETY WHO WERE IN ARREARS, AND THE SOCIETY IS, THEREFORE, ON THE HONOR ROLL OF THOSE SOCIETIES SHOWING STATE DUES PAID FOR THE ENTIRE MEMBERSHIP.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES
FLORIDA MEDICAL ASSOCIATION

County Society	Secretary	MEETINGS				Dues Paid
		Date	Time	Place	Luncheon?	
Alachua	W. Lassiter, M.D., Gainesville.					70%
Bay	J. M. Nixon, M.D., Panama City.					100%
Bradford	Seeber King, M.D., Lake Butler.					100%
Brevard	R. D. Ferguson, M.D., Titusville.					100%
Broward	Leigh F. Robinson, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Commerce	No.	100%
Columbia	L. J. Arnold, M.D., Lake City.					82%
Dade	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.	81%
DeSoto	C. H. Kirkpatrick, M.D., Arcadia.	1st Monday	8:00 P.M.	Hospital	No.	75%
Duval	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.	100%
Escambia	Herbert D. Snyder, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	95%
Four Counties	G. C. Hardie, M.D., Ft. Pierce.					20%
Hillsboro	B. W. Lowry, M.D., Tampa.	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.	96%
Jackson	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.	96%
Lake	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	100%
Manatee	J. M. Davis, M.D., Bradenton.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.	90%
Monroe	G. R. Plummer, M.D., Key West.					88%
Orange	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Announced	No.	89%
Palm Beach	W. O. Arnold, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Monterey Hotel	Yes.	100%
Pasco	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.	91%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every 2nd Friday	8:00 P.M.	Fla. Art School	No.	99%
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr. June, Aug. Oct., Dec.	1:00 P.M.	Lakeland	Yes.	91%
St. Johns	I. M. Hay, M.D., St. Augustine.	3rd Monday	8:30 P.M.	Varies	Yes.	91%
Sarasota	F. Metzger, M.D., Sarasota.					100%
Second District County Medical Society	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	88%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Selected	No.	86%
Taylor	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	78%
Volusia	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	88%
Walton	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	88%

NOTE

(Secretaries: Please submit information to complete the above schedule.)

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Rabies Vaccine (Cumming), P. D. & Co., is made by the method devised by Dr. J. G. Cumming. A one per cent suspension of rabic brain tissue (from rabbits dying of rabies induced by an injection of fixed virus) is dialized against running distilled sterile water until the infectivity of the virus is destroyed. The safety of the finished product is assured by injections beneath the dura of rabbits and subcutaneously in guinea-pigs and mice. Sterility tests are also utilized to insure freedom from bacteria. The vaccine is standardized by weight so that 2 cc. of suspension, the contents of one of the syringe containers, contains sufficient material for one injection for an adult.

The safety and efficiency of Rabies Vaccine (Cumming), P. D. & Co., has been amply demonstrated by its employment in at least ten thousand cases of bites from rabid animals. The usual treatment consists of twenty-one injections—one injection daily for three weeks. A shorter course—one of fourteen injections only—suffices when the wound is only a slight scratch on the hands or lower limbs.

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In order to end this indefensible and even dangerous situation the United States Pharmacopeia has now stepped into the breach with a definite standard of activity, and it is cause for gratification that this standard is the exact equivalent of that which we have maintained for Pituitrin "O" during many years. Not only that, but the same step has been taken also by the League of Nations. At the Geneva Conference last year an international unit for pituitary extracts was adopted, and a product having a potency of ten units per cc has the same strength as that now recognized by the U.S.P. and that established by us long ago for Pituitrin "O".

It is to be hoped that the establishment of both an American and an International standard for pituitary extracts will in part correct a situation which has become intolerable. At least a definite standard of strength now has the stamp of government authority. Gratifying as this is, however, it remains to be said that all pituitary extracts will not henceforth be of equal virtue.

Entirely apart from the question of potency, we have established other standards for Pituitrin which have not yet been written into official requirements. As the result of 18 years of steady and continuous work on Pituitrin we have developed a product which in uniformity, in stability, and in *low content of protein matter* surpasses any other pituitary extract which we have been able to find on the market and subject to examination in our laboratories.

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THE N. Y. ACADEMY OF MEDICINE
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CONTENTS

PAGE

Some Observations Upon the Surgical Treatment of Chronic Gall-Bladder Disease 58
J. Knox Simpson, M.D., F.A.C.S., Jacksonville.

Surgical Treatment of Goitre 63
LeRoy A. Wylie, M.D., St. Petersburg.

Chronic Endocervicitis 67
Ben Manhoff, M.D., Jacksonville.

A Proposed Improvement in the Serological Diagnosis of Syphilis 69
W. W. Kirk, A.M., M.D., Jacksonville.

Plicectomy 71
C. J. Heinberg, M.D., Pensacola.

PAGE

Notes on Roseola Infantum 72
Nathaniel L. Spengler, M.D., Tampa.

Report of Three Cases of Metastatic Carcinoma in Bony Structures 73
G. Raap, M.D., Miami

Editorials: (1) Florida Hospitals; (2) Ivy Poisoning; (3) Newly Organized Societies 74-76

State News Items 76

State Board of Health Notes 79

Advertisers' Notes 80

Schedule of Meetings—Component Societies Florida Medical Association 82

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SOME OBSERVATIONS UPON THE SURGICAL TREATMENT OF CHRONIC GALL-BLADDER DISEASE*

J. Knox Simpson, M.D., F.A.C.S., Jacksonville.

If we could trace backward the line of thought and reasoning which has brought us to an erroneous conclusion, concerning any problem which we have endeavored to solve, we would find out that at some point along the line of reasoning, probably at the very beginning, we have viewed some single fact alone, without getting the perspective which comes to us from viewing the same fact amid its normal modifying surroundings. I feel that this more or less axiomatic statement is particularly true concerning our attitude toward chronic gall-bladder disease, and that it should be kept in mind in our efforts to properly solve these problems.

During a recent review of our gall-bladder records I was somewhat struck by the difference in the problems involved in three cases which came along consecutively, so I have decided to review these three cases briefly, and to discuss certain points in the diagnosis and treatment which are brought out by these records.

Patient number one was referred to me by Dr. Stanley Erwin, for consultation and advice, concerning a major symptom complex, referable to the left brachial plexus, and consisting of the usual symptoms of brachial plexus neuritis, which had been present at intervals for twelve years. The usual search had been made for focal infection which would explain the trouble, and six months previously, Dr. Erwin had advised her to have her tonsils and two dead teeth removed, which had been done without relief of her neuritis. We went over the case again together, and elicited a minor symptom complex, which had been submerged in her mind beneath the greater troubles of her neuritis, and which pointed definitely to the gall bladder. The symptoms were as follows: Sour stomach, eructations of large quantities of gas from the stomach, a full and uncomfortable feeling in the epigastrium, especially after meals. She had incriminated and eliminated from her diet first one food and then another until she was on a very restricted diet, a rather typical story in these cases, without relief from her symptoms.

Physical examination revealed no abnormal findings except a rather large and boggy cervix, the site of a chronic endocervicitis, and tenderness to deep-hooked finger palpation over the gall bladder, aside from the local findings of tenderness in the course of the brachial plexus on the left side and some weakness of the muscles supplied by these nerves. Fleuroscopic examination of the chest was negative, and X-ray examination of the cervical spine in a search for cervical ribs was also negative. Laboratory examinations were all negative. The search therefore for a focus of infection which might be acting as the original cause of the brachial plexus neuritis had pointed the finger of suspicion at two sites, the chronic endocervicitis which could be seen and the chronic cholecystitis which was discernable through the clinical history only. We advised cautery of the cervix and cholecystectomy, to which advice the patient acceded.

At the operation the gall bladder was found to be white, the walls somewhat thickened and containing deposits of fat, and the omentum loosely adherent to it. It was removed, and the appendix, which was obliterated, was removed, and the cervix was cauterized by the Hunner method. The gall bladder when opened proved to be one of the typical strawberry type without stones.

The patient was completely relieved from her digestive symptoms in three months, and of her neuritis in six months, and has had no return of either.

This case represents a type where careful history-taking and the maintenance of a perfectly open mind by the examiner is absolutely essential in the process of taking a physio-pathological inventory of the patient's physiological symptoms. Her presenting symptoms of neuritis were so pronounced in her own mind that it was difficult to elicit a clear history of her subsidiary troubles, which were in reality the principal lead in discovering the cause of her major disability.

Thoughts of this case could easily lead us off

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

into the entertaining field of focal infections, but we will resist the temptation and say only that our experience leads us to consider the gall bladder as one of the distributing points of bacteria with selective propensities, which must be considered in searching for such a site, and which should be sacrificed if diseased. In this particular case there was a second site of chronic infection in the cervix, so that we cannot say which focus was responsible for the neuritis, but the fact remains that when both were eliminated she recovered from both the neuritis and the digestive disturbances.

The second case, also treated in conjunction with Dr. Stanley Erwin, gave as her chief complaint recurring attacks of severe migraine; the typical syndrome of headache getting progressively worse for a few hours, and then the appearance of nausea and vomiting, first of the stomach contents and then of the bile-stained duodenal contents.

She was a married woman of forty years of age, who had had no children and no miscarriages. The migraine attacks had begun eight years previously and had gotten progressively worse. She had had some slight digestive disturbances between attacks, chiefly gaseous eructations and epigastric distress after full meals. The gastric symptoms were usually worse for a few days prior to the attacks of migraine. There was no history of colic nor inflammatory attacks.

Physical examination was entirely negative except for tenderness to deep-hooked finger pressure under the right costal margin. Laboratory examinations showed as the only abnormal findings a subacidity of the gastric contents and a pure culture of colon bacilli from duodenal drainage (the latter finding having no import in my opinion). X-ray study showed a slight deformity of the first portion of the duodenum, which was found to be rather fixed in a high position under the liver, as the only abnormal finding.

You see then that the finger of suspicion pointed in a rather equivocal manner to the gall bladder as the offending organ. In view of some past experiences with relief of the migraine syndrome following cholecystectomy, and of the scattered evidence of chronic infection in this organ, we placed the facts squarely before her, and she decided to take the chances of relief which operation offered her.

At operation the duodenum was found to be attached to the gall bladder by a few loose filmy adhesions. The gall bladder was thin-walled, blue, and apparently a normal organ as far as we could tell grossly. There were a few white spider-like streaks on the superior surface of the liver, adjacent to the fundus of the gall bladder, indicating an old lymphangitis, and the glands along the ducts were slightly enlarged. The pancreas was normal. The gall bladder, after removal, was opened and contained three small polyps and no stones. The patient made a smooth recovery from the operation, and has been completely relieved of her migraine attacks since.

A survey of the record of this case directs our thoughts into several interesting channels. In the phraseology of the legal fraternity, they consist, first, of the accumulation of sufficient evidence to warrant the grand jury in indicting the gall bladder; second, the trial, conviction and execution of the organ; and, third, a consideration of the relief afforded the human community in getting rid of an offending member.

The evidence upon which an indictment was reached was the rather typical reflex gastric disturbances, the attacks of migraine headache, and the evidence of interference with the functions of the first portion of the duodenum from adhesions.

The trial consisted of an exploratory incision which gave us a view of the gall bladder in its natural living environments and of its effects upon its neighbors. Here let me say that a consideration of the gall bladder alone showed what we would consider a normal organ, thin-walled, blue and collapsible. Not so its neighbors, however, for here was the telltale evidence of misbehavior. The duodenum was adherent to it, the glands along the ducts were enlarged, and there were the fine white lines of scar in the adjacent liver which told the story of an old-time criminal.

The relief obtained by this patient and others whom we have had of this type is probably explainable upon the basis of a rather recent explanation of certain migraine syndromes which have been found to be due to dilitation of the first portion of the duodenum, stagnation of the duodenal contents, and a resulting duodenal intoxication, analogous to that present in the first stages of high intestinal obstruction. Crile, in a talk given before the College of Surgeons in New Orleans in January, stated that at the Cleveland Clinic they had succeeded in recognizing this duodenal dilitation with the fleuroscope

in a good many cases, and had done thirty odd duodeno-jejunostomies as a relief measure, obtaining relief from the migraine attacks in about 90 per cent of the cases. This would offer a rather tenable explanation for the temporary relief obtained in some of these cases from medical drainage of the gall bladder by the duodenal tube, the drainage serving to empty the toxic duodenal contents rather than the gall bladder.

The third case represents late gall bladder pathology, and presents a much more difficult problem in treatment than in diagnosis.

The patient, a woman fifty years of age, came in complaining of upper right abdominal pain and tenderness, jaundice, nausea, and inability to eat because of pain in the region of the gall bladder after meals. Her gall-bladder history dated back over a period of six years, two years of typical attacks of gall-stone colic, culminating in an attack of empyema with its attendant chills, fever, and rather extreme toxemia. She was operated upon during this attack by one of our local surgeons, who very properly did nothing more than remove some stones from the gall bladder and put in a drain. A biliary fistula resulted and drained for eighteen months, after which time it had intermittently opened and closed for a year, jaundice coming on when it closed, and disappearing when it opened. For eighteen months before I saw her the fistula had remained closed, but the intermittent jaundice had continued. She had been under treatment for three months by the so-called medical gall-bladder drainage when she came to me.

Examination showed a big fat woman, weighing 180 pounds. The skin was rather markedly jaundiced. The physical examination was negative except for the abdomen. There was an upper right rectus scar, and rather marked tenderness to pressure over the gall bladder. The liver dullness was enlarged to four finger breadths below the costal margin. Pelvic and urological examinations were negative. There were no abnormal laboratory findings except a high bile content of the urine. Coagulation time of the blood was three minutes. A diagnosis of ball-valve stone in the common duct was made and operative relief advised. She was prepared for operation by being filled up with fluids and given calcium chloride.

At the operation, which was done under combined novocain abdominal field-block and gas anæsthesia, the gall bladder was found to be thick-walled and covered by the adherent omentum and duodenum. There was a fistulous opening between the gall bladder and the duodenum, in which was found two small impacted stones, one of which was pushed into the duodenum during the manipulations and vomited by the patient the next day. The gall bladder contained several more stones and normal bile. The cystic duct was slightly dilated, and the common duct dilated to the size of my thumb. The common duct was opened and three loose-floating stones removed. Exploration of the duct with the little finger disclosed a fourth stone, tightly impacted in the ampula of Vater. Apparently it could neither be milked up the duct nor pushed into the duodenum, and I was about to do a transduodenal removal when I succeeded in dislodging it with a stone forcep and removing it through the common duct incision. The gall bladder was removed, the duodenal fistula closed, and the common duct drained by a T-tube. A drain was placed in Morrison's pouch and the wound closed. The patient had a few days of rather stormy convalescence accompanied by a good deal of vomiting, but made a satisfactory final recovery, the wound being healed in five weeks. She has been perfectly well since, with the exception of the fact that she has a ventral hernia, the protrusion being about the size of half an orange.

There are several points worthy of thought and comment in this case:

First—The diagnosis was plainly apparent as concerned the site and the probable nature of the pathology.

Second—The indications for surgical treatment at the time of her first operation were clear-cut, and the surgical judgment of the man who did the first operation was proven by the fact that she was still living. It is true that the stones were very likely present in the common duct at the time of her first operation and were left there. Here, however, was a patient at the height of an attack of infection in the gall bladder, plus a liver whose function was acutely interfered with by the back pressure of a closed biliary system. The indications were to establish drainage of the infected contents of the gall bladder and decompression of the liver cells, and nothing more. More radical surgery at that time would have probably resulted disastrously for the patient. It takes a good surgeon to know when to quit.

Third—The case illustrates the admirable response and ingenuity of nature's forces of re-

pair, in coming to our rescue in time of need. The infected gall-bladder fundus was evidently adherent to the duodenum, so when the operative fistula kept closing up and reestablishing the closed biliary system, nature proceeded to do a defensive cholecyst-duodenostomy, thereby establishing permanent gall-bladder drainage and short-circuiting the obstruction of the common duct. Had it not been for the stones in the gall bladder getting impacted in the fistula at recurring intervals, she might have completely solved the problem and cheated us out of an operation.

Fourth—Surgical treatment of the case at the time she came to us was plainly indicated by her failure to get either automatic relief, or relief from medical drainage, from her recurring attacks of pain, nausea, vomiting and jaundice. That our preoperative explanation of the cause of her attacks as being due to a ball-valve stone in the common duct was wrong may be excused upon the basis of the rarity of the condition found. That we were wrong, however, does not render the indications for surgical treatment any less sound. The patient at the time we saw her except for the jaundice, was in good condition for radical surgery, the second stage of the two-stage operation which had been begun four years previously. Of course we would prefer her having an intact abdominal musculature, but we do not feel particularly chagrined at having a postoperative ventral hernia in a case of this kind, when the patient is perfectly well in every other way.

Fifth—I wish to comment upon one point in the technical details of this operation which has cropped up several times in our experience with gall-bladder surgery. It was impossible to recognize the impacted stone in the ampula from palpation of the duct before it was opened, and no grating sensation was imparted to the olive-tipped probe or the scoop which were used to explore the lower end of the duct. It was only possible to recognize the obstruction in the duct as being due to stone, by feeling the stone with the tip of the little finger inserted in the opened duct.

Summarizing our attitude toward chronic gall-bladder pathology, based upon a review of our records, I would say:

First — The pathology of the gall bladder should not be considered alone but in conjunction with and as a part of a more widespread process, involving usually the liver and ducts, sometimes the pancreas and duodenum, and occasionally more distant sites.

Second—In arriving at a diagnosis we utilize all the tests at our command, but put most of our dependence in an accurate and carefully taken history. I would say 60 per cent of our evidence is obtained through the history, and the remaining 40 per cent from a combination of physical examination, X-ray and laboratory tests.

Third—In deciding upon the feasibility of an operation, and estimating the patient's reserve strength and ability to withstand an operation, we cannot overestimate the value of the services of a good internist, or of the patient's physician, who has seen and knows about how much of a load she can carry.

Fourth—In rendering the operation as safe as possible we utilize the judgment of the internist concerning the necessity for preoperative digitalization of the heart, and make use of the principles of getting the patient's body-fluids up to a high level; and in the presence of jaundice lowering the coagulation time of the blood by the administration of calcium chloride, as advised by the Mayo Clinic.

Fifth—About the only cases in which we do not now remove the gall bladder at operation are those where we cannot find any evidence of pathology present and those cases where occlusion of the common duct, or the extreme condition of the patient, renders the operation too hazardous and makes a two-stage operation the policy of safety.

DISCUSSION

Dr. W. C. Payne, Pensacola:

I merely want to emphasize that part of Dr. Simpson's paper in which he calls attention to the necessity of using every means at our disposal in making a diagnosis of chronic gall-bladder disease. If every case could be studied as carefully and as impartially before and at operation as were the cases reported by Dr. Simpson, there would be fewer disappointments in gall-bladder surgery.

Two of his cases were those that we might term borderline cases, in so far as the pathology was revealed at the time of operation, and his decision to remove the gall bladder was not arrived at until he had taken into consideration every angle possible in the history and examination of these cases. That he chose wisely is proved by the results.

I know of no condition that requires more detailed study and more sound judgment than in the decision as to whether the gall bladder is infected or not, in some cases. And it is probable that no operation that the surgeon does is followed by more spectacular results than the removal of a badly diseased gall bladder. This fact, however, is likely to make us become overenthusiastic to remove the gall bladder—sometimes unnecessarily.

I think that a warning should be given against promiscuous and indiscriminate removal of gall bladders.

In any procedure with as high mortality as accompanies the removal of gall bladders, one will certainly come to grief sooner or later unless he confines himself to those cases in which the indications are reasonably definite.

Dr. Stanley Erwin, Jacksonville:

Anyone doing routine diagnostic examinations will be impressed with the number of times that his patients present the gall bladder as a suspicious area of infection. This happens so many times that I am beginning to think that perhaps I have developed a habit of making a diagnosis of gall-bladder disease.

Two of the patients reported here by Dr. Simpson have been taken from a series of over fifty patients that have been under study; some of these have been operated with uniformly good results. The non-operative cases either refused or had complications.

The second case of those reported by Dr. Simpson is different. Dr. Simpson does not give himself all the credit due because he made the extremely difficult diagnosis of gall-bladder disease. She was referred to him with only a suspicion. This woman had a total absence of a vagina, an infantile uterus with rudimentary ovaries. She had married, at an early age, not knowing her abnormality, and had had two reconstructive operations and an exploratory laparotomy. Twelve years ago she had had an operation for a retrocecal adherent abscessed appendix. Her ovarian secretion was of course not normal, she had everything to impress a psychoneurosis neurasthenia on her personality. All the endocrinology known has been applied to this woman; as stated, migraine headache is her chief symptom. Dr. Simpson diagnosed gall-bladder disease and removed the gall bladder. I saw this patient about three weeks ago, she is having no trouble.

These victims of gall-bladder disease are seen in middle-aged adults. Here is a combination of, first, teeth and tonsils; second, gall bladder and appendix, or an infected cervex or prostate. You have to rule all of these things out. Most of these patients have secondary pathology. If the surgeon operates before the secondary pathology develops then his results are good, provided his diagnosis is correct. If there is an old myocarditis with coronary disease, his patient does not get well. In the study of gall-bladder disease heart conditions occupy a prominent part. You will notice a great number of patients with the diagnosis of coronary disease accompanied by gall-bladder infection; they go together.

Medical treatment of chronic gall-bladder disease is useless because you cannot remove the cause of infection. All of the patients have been subjected to gall-bladder drainage. Sometimes they get results for one month, six weeks or two months, but eventually all go right back again.

All operative cases of any kind with chronic infection should be digitalized, also should be studied for heart reserve. If this is done, I believe mortality would be lessened.

It grieves me very much for a surgeon to get a 100 per cent result on a patient whom I have been treating for ten years, but I will have to admit the facts in the case operated on by Dr. Simpson.

Dr. John E. Boyd, Jacksonville:

I will just talk a little bit about gall-bladder disease—about the patient that comes to you and says she is having *"bilious attacks"*. The outstanding statement in this paper is when Dr. Simpson says, *"headache followed by nausea and vomiting."* This sequence of symptoms is the one that the general practitioner has got to pay more attention to. It is this type of patient that runs from one doctor to another, month in and month out, year in and year out and gets calomel, phosphate of soda or mineral oil—and every time they are purged they feel better. A majority of these patients are gall-bladder cases.

Now, there is just one other thing about these gall-bladder cases that has been stressed by Dr. Erwin's discussion of the second case, i.e., six or seven years prior to the gall-bladder operation she had a retrocecal appendix with abscess. Gentlemen, if you have an old chronic retrocecal appendix, take a look at your gall bladder. Vice versa, if you have a chronic gall bladder, with adhesions, take a look at the appendix. I was

operating a case just the other day which had had a negative dye study. Clinically, I thought it was a diseased gall bladder, but the X-ray report said not. I turned the patient over to Dr. Erwin for examination and he found a mass in the hypochondrium. None of us could explain the nature of this mass. I told the patient none of us knew what it was and advised an exploratory operation. I found the gall bladder practically covered with adhesions; adhesions to the duodenum and to the hepatic flexure of the colon; I also found an old chronic retrocecal appendix. The gall bladder was removed and submitted to the pathologist, who made a report of chronic cholecystitis. It is too easy to trip up in these patients. This was another one of those cases of headache, nausea and vomiting that had been fussing around for six years.

Another case came up lately that I thought had gall-bladder disease, but Dr. Cunningham and Dr. Shaw said no, it was a duodenal ulcer. I operated on him seven days ago and found the gall bladder practically covered with adhesions; there also was a duodenal ulcer; also a retrocecal appendix, adherent to the posterior peritoneum. I believe in that case the primary pathology was the appendix; the gall-bladder disease followed that and the ulcer was a still later sequel. There was also evidence of chronic pancreatitis.

Now, how much are you going to be able to do for them, at this stage? I don't know. I believe, in all these cases the gall bladder should be taken out and the common duct should be drained in order to take care of the pancreatitis.

CONCLUSION

Dr. J. K. Simpson, Jacksonville:

I purposely did not go into great detail on these case-histories because I did not have time.

I agree with Dr. Boyd that the appendix is very frequently the original site of infection. It will cause not only gall-bladder disease, but sometimes duodenal ulcer from hematogenous infection due to bacteria derived from the appendix region.

I did not get a chance to discuss the paper on dye in gall-bladder work this morning, and I want, at this time, to acknowledge my indebtedness to Drs. Cunningham and Shaw for helping me in my gall-bladder work with the administration of dye.

There is one positive value in dye administration that I do not think was brought out this morning. Like everyone who has done any extensive amount of gall-bladder work, I have at times opened abdomens and had gall bladders in my hands and could not tell whether they were diseased or not—could not tell whether I ought to take them out or not. Some that I have left have been well, and some I took out and was sorry afterward that I did. It is absolutely impossible at times to tell from the external surface of the gall bladder, or after splitting and looking at the internal surface, whether that gall bladder contains sufficient pathology to warrant its removal or not. This dye, as was stated by Dr. Graham, promises to give us an insight into abnormal physiology of the gall bladder so that our cholecystectomies can be based upon the removal of an organ which has abnormal physiology even though we cannot see pathology in the organ. All of us hate to take out an organ unnecessarily, and if we have a patient who has clinical symptoms of cholecystitis and we open the abdomen and see a perfectly normal gall bladder, we know it is either up to us to go ahead and take it out and take a chance that it is diseased, or acknowledge that we are wrong and close up. If dye can give us a physiological basis for the removal of these gall bladders, even if they look normal, and then later we can find out from microscopic study that this condition is really based on abnormal microscopic pathology, I think it has gone a long way toward helping us out in solving this difficulty.

SURGICAL TREATMENT OF GOITRE*

LeRoy A. Wylie, M.D.,
St. Petersburg.

The present accepted methods of treatment of goitre are rest, radiotherapy or radium, and surgery. As the results of the first three of these are so inconstant and insufficient, surgical intervention is the method of choice. There is no doubt that physical and mental rest, the X-ray and certain of the universally employed medical measures are beneficial in some cases. The repeated injection of hot sterile water (5-10 c.c.) into the thyroid alleviate the clinical signs and symptoms of hyperthyroidism. Many make the mistake of administering iodine indiscriminately, frequently exaggerating the symptoms even to the toxic, or so-called iodine Basedow. Yet by

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

the proper use of Lugol's solution the need for ligation has fallen from 50 to 90 per cent in some clinics, with marked improvement in the patient's nervous system and a fall in the pulse and metabolic rate.

The results are most spectacular in the exophthalmic type. Too often we wait too long and experiment with too many forms of medication. In the meantime the disease progresses beyond our control, the organs become vitally damaged and the outcome grows dubious.

From the epoch-making work of C. H. Mayo, Crile, Halstead, and others, it is a recognized fact that thyro-toxic cases can be benefited and cured by surgery. A study of the statistics bears out their statements.

Surgical treatment is the safest, surest, best and most satisfactory way of handling the disease. By selecting a type of operation which exactly fits the type of case, we have done a great deal to decrease mortality in cases of goitre.

Pathological study of goitre now gives us a sharply defined picture of four types, according to L. B. Wilson. These are:

First—Toxic Exophthalmic.

Second—Toxic Adenomata.

Third—Non-toxic, or simple goitre of the colloid type.

Fourth—Malignancy.

When once an operation has been decided upon, the judgment and experience of the surgeon will be largely the determining factor for the safe outcome of the case. Then there comes next the mastery of the surgical technic, and third, the proper attention paid to the heart and nervous system of the patient, and the anesthesia used. No type of operative case requires more diligent study and personal touch than prospective thyroidectomies, because such patients are extremely nervous, irritable and sensitive.

Hospital accommodations should be made in advance, patients should remain in bed continuously and every effort made to keep them quiet and free from the usual excitement and disturbance of hospital routine. The most important factors are the examination of the heart and kidneys, resorting to the functional test if needed. In severe heart complications such drugs as digitalis m. xx q. 4 h. for 20 doses, or quinidine and soda may be used, not necessarily to lessen the tachycardia but to better prepare the myocardium for the added strain that is to be put upon it by the operation. Sodii Bromidi, B.I.D., for rest. They do not, as a rule, tolerate morphine well.

In severe toxic cases the patient should be deceived as to the time of operation by giving a hypo. of sterile water daily for several mornings, and if the case is very nervous, a few inhalations of gas anesthesia in bed before breakfast. The day of operation, 1/6 gr. heroin is given half an hour before moving to operating room. It is seldom necessary to administer anesthesia before leaving the room. From the study of the clinical findings, during the pre-operative care, one may classify indications for the kind of operation as follows:

1. Bilateral resection with the wound open.
2. Bilateral resection with the wound closed.

No gentleness in operating, no advantage given by medical means can be neglected. The important thing is the graduated operative procedure, in severe cases.

Post-Operative Treatment: Place patient in Fowler's position so that he can clear the throat of mucus more easily; morphine gr. 1/6 q. 2 h., S.O.S., to keep perfectly quiet; water given by all routes, since the greater the fluid intake the sooner the recovery from the operation. A Murphy drip of 400 c.c. Sodii Bicarb. and glycose, 5 per cent solution; repeat in 4 hours, S.O.S. Ice cap to heart continuously. For discomfort caused by the mucus in the trachea, steam inhalations of Tr. Benzoin. Occasional ice pack has to be resorted to for the control of rising temperature and delirium, remembering always that for every degree of temperature rise metabolism increases 10 per cent, so that it is no wonder these cases lose control with the disturbance of the heat centres. This last is a radical measure.

A uniform technic does not exist in goitre operations, but fundamental differences are no longer possible. Fifteen or twenty years ago thyroidectomy meant take the goitre out, close with or without drainage and trust to luck. Today views are different.

Before operation we want to have constantly present in mind a few particular anatomical facts from which we will derive certain important technical procedures:

(a) To leave the parathyroid and the inferior laryngeal nerve uninjured.

(b) To leave enough thyroid tissue to protect the patient against hyperthyroidism.

(c) To protect the patient against future relapse.

(d) To obtain as fine and nearly invisible a scar as possible.

To illustrate, let us take one case:

Toxic adenomata, Bilateral Resection, with secondary closure. No. 1206, female, age 35. Housewife, married. Childhood diseases: measles, mumps, chicken pox, whooping cough. No serious illness; no injuries. Tonsillectomy 3 years ago. Menses began at the age of 12, very irregular, profuse flow, 7 days' duration; no menorrhagia; no pregnancies.

Three years ago examined by physician because of increasing nervousness and extreme shortness of breath. Last 6 months loss of weight 11 lbs. She has headache most of the time and is very easily excited. Patient is so weak at times she is unable to work about the house. Sleeps poorly because of her heart palpitation.

Physical examination: Well developed; weight 141 lbs. Pupils equal, react to light and accommodation; no prominence or increased tension. Throat negative; tongue tremulous. No definite muscle tremor. Thyroid enlarged bilaterally, size of a small lemon, pulsating. Circumference of the neck 19 inches. Pulse, varying from 120-130. Heart sounds irregular and rapid; no murmurs. Blood pressure, 128. Urinalysis, negative. Coagulation time, 7 minutes; hemoglobin, 80 per cent. Basal metabolism, plus 46 per cent.

The first few days in the hospital she was unable to sleep, very excitable, and cried most of the time. Bromides were given and ice bag to the heart. The time for operation was kept from the patient. Each day, for two days before, her neck was cleansed with 30 per cent alcohol and a dry dressing applied. The morning of operation the neck was painted with 3 per cent iodine and protected with a dressing. She also received 1/6 gr. heroin, one hour before operation. This method has proven very successful in lessening the nervousness, excitability and anxiety.

After 5 days in the hospital, patient was taken to the operating room. Gas-oxygen was administered, the skin infiltrated along the line of incision with a one-half of one per cent novocain solution, no adrenalin being added. Skin, facia and platysma were cut transversely; superficial bleeding controlled by retractors. Dissection was carried out longitudinally, between the sternohyoid muscles; transversely, through the omohyoid muscles. The sternocleido mastoid muscle was retraced, the surgical capsule incised longitudinally, and the gland enucleated from without inward toward the trachea. This allows the operator to see the parathyroid and recurrent laryngeal nerve. The lower pole was liberated first, and the inferior and superior thyroid vessels ligated. In enucleating the gland 1/5 was left, using the Crile thyroid clamps. The same procedure was repeated on the opposite side. A continuous suture, No. 1, iodinized catgut was applied to the stump. The wound was flushed with 30 per cent alcohol solution, which seals up tissue spaces against thyrotoxic juices, and packed with gauze, protecting the skin edges with rubber-dam.

The patient's condition remained excellent, her color good.

Twenty-four hours later heroin was repeated, gas-oxygen given and the packing removed. The muscle edges were approximated (subcutaneous catgut suture or clips may be used) and a small rubber drain left for 24 hours; a glycerine and alcohol dressing was applied. The patient was up on the fourth day and home on the ninth day, with the wound healed. Metabolism test sixteen days after operation, 11.2 per cent. Marked improvement in general symptoms.

In conclusion, we may draw the deduction that proper diagnosis in a goitre case is essential, that every advantage of pre-operative procedure brings the best results.

(1) The early mild forms of hyperthyroidism in a young individual should be treated medically.

(2) The early typical cases are surgical. In this class of patients surgery can boast of almost 100 per cent cures, and a low mortality.

(3) In the well-advanced typical cases no time should be lost before an operation.

(4) In severe cases of long standing, where the whole organism is completely disorganized and organic changes in heart, liver and kidneys have become marked, the time of surgical procedure is often past. Radiotherapy in the exophthalmic type and injections of boiling water afford some relief.

Cooperative work between the physician and the surgeon is absolutely essential to produce successful results in these cases.

DISCUSSION

Dr. John S. Helms, Tampa:

The problem of the thyroid gland is quite a serious one, at least we are beginning to realize

that the thyroid gland is probably diseased more frequently than we were accustomed to realize heretofore. We heard Dr. Bitzer's paper this morning on basal metabolism, and we heard a great deal about hypothyroidism. I think, of course, that in all cases where the thyroid gland is diseased, or there is an enlargement with hyperthyroidism, the case is probably a surgical one. I don't believe that radiotherapy, either by radium or X-ray, is a valuable means of treatment in enlargement of the thyroid gland with hyperthyroidism unless there are such complications that surgery cannot be applied to the case. On the contrary, I rather believe that treatment by radium or X-ray complicates the final operation that will have to be done in those cases that are suitable for operation. I believe that the operation should be proceeded with at once after the proper preparation of the patient. I believe that radiotherapy and X-ray therapy increase the complications and the surgical risk about 50 per cent, produce adhesions, as a rule, and complicate the operation otherwise.

I don't think that there is anything in the field of surgery in which we get more uniform and more perfect results than we do from the proper sort of surgery of the thyroid gland. The question of the proper preparation of the patient is a very important one and should be looked after very carefully. I don't think that the cases with very high metabolism rate should be attacked surgically without a great deal of study and a great deal of preparation. We have lately been using Lugol's solution to correct the basal metabolism rate, and I think that answers every purpose, instead of the preliminary operations that we did before, in so far as getting the patient ready for the final thyroidectomy. The type of lesion, of course, determines to a large degree the technique of the operation and determines also to a large degree the risk of the operation, also, largely, the final result of the case.

Thyroid operation in itself, in so far as technique is concerned, is really a very simple affair, and, of course, the few essential anatomical parts should be well known to the surgeon and properly preserved. The results, as I have said, are exceedingly good, and I think that this is work that should be taken up by a greater number of men, and the subject is an important one. I enjoyed very much hearing Dr. Wylie's paper.

Dr. J. S. McEwan, Orlando:

This subject has been very well covered by the two preceding talks, and there is only one point that I wish to bring out.

The essayist spoke of giving Lugol solution. Many internists give Lugol solution and they give it too long. Lugol solution is the proper medicine in preparing your exophthalmic goitre cases for operation, but after it is given up to a certain point, then it should be stopped and you should have your operation. But many cases today are coming to the surgeon being over-treated with Lugol solution, and then the choice time of operation is past.

This is the thing I wish to leave with you: Do not over-treat your patient with Lugol's solution.

CONCLUSION

Dr. LeRoy Wylie, St. Petersburg:

From a purely selfish standpoint, I hoped that there would be greater discussion. To my mind, an ordinary surgeon, unless he has had special study on thyroidectomies and the operative work for hyperthyroidism, should leave the neck alone. He would not attempt to do nose and throat surgery without special study.

Our friends across the "Big Pond" have just put out some very interesting work on the etiology of the hyperthyroidisms. I was trying to recall the professor's name who has done some epoch-making work in discovering what we call the viable virus. If his findings are true, gentlemen, you and I are going to look upon hyperthyroidism in an entirely new light. Our methods will be completely revolutionized.

The general practitioner, as a rule, sees these mild and moderately severe hyperthyroidism cases, and it is true that they do use Lugol solution indiscriminately. However, it is an excellent thing while you are studying your case to give Lugol. The patients themselves will very quickly tell you that the iodine is not needed. I cannot lay too much stress on the early study and preparation of these cases.

In handling these thyroids, the technique, to my mind, should be carried out as I said this morning, and is most essential, i.e., the manipulation of the gland itself, the putting of your hand into the wound, and in bringing out this subject I tried to lay emphasis on the technique so that we general surgeons could go ahead and combine thyroidectomies with our general work.

CHRONIC ENDOCERVICITIS*

BEN MANHOFF, M.D.,
Jacksonville.

Among the lesions met with in gynecology that are exceedingly common, therefore usually neglected, are the chronic infections of the cervix uteri. With the exception of infections due to gonococcus, and possibly those resulting from attempted abortion, it is probable that they develop insidiously without an apparently acute stage.

The cervix is one of the most insensitive parts of the body, and diseases of that organ, inflammatory or otherwise, give little or no pain. The discharge resulting from the first infection may be overlooked by the patient. However, as the lymphatics which drain the cervix are continuous with those of the uterus and parametrium, the cervix is, and rightly so, called the uterine tonsil, and unless its lesions are given attention, chronic metritis, subinvolution, pelvic cellulitis and other painful and permanent pelvic lesions may follow.

Chronic endocervicitis is the source of most leucorrheal discharge which is a cause of distress to so many women. Directly or indirectly, it is responsible for much of the sterility in women, and it is believed that it increases the possibility for cervical cancer.

Many women complain of dyspareunia, backache, pelvic pain or soreness in the lower quadrant of the abdomen with no history of definite attacks of salpingitis and with some tenderness of the adnexa, but no palpable enlargement or fixation. A careful pelvic examination, which must include inspection of the cervix and therefore a speculum examination is essential, frequently reveals an enlarged chronically congested cervix with a discharge distinctly mucopurulent in character, or it may be honeycombed with small cysts. There may be an area of the cervix that is red and angry looking with eversion and prominence of the mucosa, the so-called erosions, with little or no leucorrhea. Usually the lacerations, erosions and endocervicitis are closely allied and their treatment to a large extent is the same.

Some women have an annoying, persistent and irritating leucorrheal discharge after removal of the fallopian tubes, uterus or both if the cervix has been left behind. The influence of this constant discharge often has a disastrous effect on the patient's nervous system, especially if she has been told that the original cause was a gonorrheal infection. Where it is necessary to remove fallopian tubes, attention must be paid to the cervix, as it is the original source of tubal infection.

The majority of physicians disregard chronic endocervicitis entirely or are still treating the condition by packs, topical applications or douches and obtaining little or no results. Douches have no curative effect on the disease as they do not reach the seat of infection. They merely cleanse the vagina of the accumulated secretion and prevent, to some extent, the irritation which results from the contact of the discharge with the external genitals.

The recognition that a chronic endocervicitis is a menace to the health of women and not a so-called simple, minor and only annoying ailment has led to renewed efforts to devise an efficient cure, and its successful treatment cannot be too greatly stressed.

The type of treatment must be varied according to the extent of the lesion, age of the patient, the nature of the infection and the associated pathology; nevertheless, it must always be remembered that types of treatment which are most effective in eliminating a chronic endocervicitis may result in serious complications if used during the acute stage, due to a rapid upward extension of the infection resulting in an acute pelvic involvement.

In most cases, the hyperplastic, chronically infected glandular tissue must be either removed surgically or destroyed through the use of a cautery. Other methods have been used but have certain disadvantages. Diathermy mentioned by Corbus is very effective in killing gonococcus but cannot be used in other infections, and will not heal over an erosion of the cervix. In the hands of Curtis, who has done pioneer, accurate and thoroughly scientific work in the study of the etiology of chronic leucorrhea, radium has given excellent results. It is not practical, however, for all who treat these lesions, on account of its expense and the dangers of its use in inexperienced hands. Its action cannot be limited to the destruction of cervical glands, and there is scar formation in the muscular tissue which tends to contract and cause a stenosis.

Surgery has a definite place in the treatment of the cervix. Sturmdorf, in perfecting the

*Read before the June Staff Meeting of the Duval County Hospital.

conical excision of cervical glands, made a real contribution to the surgery of the cervix. It is claimed that this operation should be avoided during child-bearing period, as it predisposes to aborption and dystocia; in my experience, if the operation is properly done, this has not happened, as I have had a number of women who have had a normal delivery following this operation. In a few cases the leucorrheal discharge, to a lesser extent, still persists, and in cases where the cervix is fixed by parametrical involvement the procedure is difficult and time-consuming. I am doing this operation less frequently because I have considered other possible means of restoring the cervix to healthy condition.

It is believed that cauterization is the ideal method in most cases, as it is a simple, effective procedure. The cautery destroys the infected, hyperplastic cervical glands, which is not replaced by scar, as proven by experimental work, but by squamous epithelium from below.

Immediately after the cautery is removed, a white area of necrotic tissue is seen. An exudate is thrown out and in a few days there is necrotic plug in the center. This remains in place about ten days, and at this time squamous epithelium is seen growing toward the canal. At the end of a month the entire eroded surface is covered. The co-version of a large erosion with a profuse mucopurulent discharge into a normal-looking cervix resembling the nulliparous cervix, with no discharge, is really remarkable. With the exception of cases that are reinfected from their husbands, persistent leucorrhea means an incomplete cauterization.

Various types of cauteries have been used, such as Downes electro-cautery knife, Pacquelin, nasal, Post, etc., and providing that the delicate vaginal mucosa is protected from burning they are all of value, as they all destroy infected glands.

This procedure has been done under a general or caudal anæsthesia or without any anæsthetic as an office treatment. With caudal injections and, of course, without any anæsthetic, the patients complain of a very marked pain due to a severe cramp in abdomen caused by spastic contraction of the uterus whenever the heated cautery is in place. As a rule it is advisable to administer a general anæsthetic, allowing the patient to leave the hospital as soon as she recovers from the anæsthetic, usually the same day.

The aftertreatment of cauterization consists in instructing the patient to wear a pad, as she is warned that there is an increase of vaginal discharge during the sloughing stage, which is usually from ten days to two weeks.

Complication after cauterization may be hemorrhage, although I have never seen a case of it, or there is a possibility of stenosis, not from scar contraction but from growing together of two granulating surfaces, chiefly at the external os. Recently I have seen a case of complete occlusion of the cervical canal causing a damming back of menstrual flow by a veil-like membrane, extending from anterior to posterior surface of external os following cauterization. Probably on account of this complication it has frequently been mentioned that it is best to first dilate the cervix before cauterization.

CONCLUSION

A careful pelvic examination must include inspection of the cervix.

Chronic endocervicitis is not a simple, minor, annoying condition, but assumes major importance.

Chronic endocervicitis is often the direct or indirect cause of sterility.

Chronic endocervicitis is curable only by eradication or destruction of hyperplastic infected glands of the cervix.

Where it is necessary to remove infected fallopian tubes, cauterization of the cervix is indicated.

The cure of chronic endocervicitis is thought to be a potent prophylactic measure in the elimination of cancer of the cervix.

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A PROPOSED IMPROVEMENT IN THE SEROLOGICAL DIAGNOSIS OF SYPHILIS*

W. W. Kirk, A.M., M.D.,
Jacksonville.

I feel that there is no one here who does not each day in his practice have the question as to whether a given patient he has seen has or has not syphilis in the background, or as the fundamental element of importance in the clinical study of the case. Because of its protean distribution, because of its multi-form pathology, and because of the tenacity of its hold upon a patient, this disease, syphilis, is every man's problem.

The routine Wassermann test, I really believe, has come to be nearly as commonly done as a routine urinalysis. In view of the fact that forty per cent of hospital population may be suspected of syphilis in some form or degree, and that fifteen per cent of the general street population is in a similar condition, this policy of routining a blood Wassermann upon at least the greater number of patients with illness of any consequence in a physician's clientele, is entirely commendable; we can only wish that the treatment of detected cases could be as adequately cared for.

I will not attempt to interest you in any of the technical detail in the performance of any blood or spinal fluid test for syphilis. There will be demonstrations at the close of the talk, but details only essential to a more satisfactory understanding of the rather knotty problem of serological diagnosis shall be retained.

Nothing particularly new will be proposed; only a more rational utilization of reliable diagnostic aid at our disposal is intended.

Wassermann, a German physician, on May 10th, 1906, reported his test upon bloods for the detection of syphilis, only antidating a French investigator in similar work by two weeks. Briefly, the principal upon which the Wassermann and all other serological diagnostic procedures for the diagnosis of syphilis is based, is the detection of the presence or absence of certain specific substances in the specimen under examination, technically known as antibodies, and the study of their activities as injurious agents upon a substance present in all bloods, technically known as the complement. This substance, complement, is present in all animal blood in more or less constant amounts. In certain diseases, notably syphilis, there is a reduction of complement in proportion to the harmful effect of the antibodies acting upon it. Here the pathological theory of an individual's reaction to a harmful agent comes into consideration, and gives the pathological conception of the cause of this disease. The Wassermann is a test for the estimation of the degree of the harmful effect of antibodies produced in syphilitic infection upon the complement before mentioned, this estimation, in technical language, being termed the binding or fixation of the complement. The early primative Wassermann test was complex in the extreme and gave little more than one-third positive tests; the very complexity and lack of standardization of technic giving the high degree of error.

A test potentially so valuable, and at the same time limited in usefulness by a cumbersome technic, has invited a world-wide and persistent search into methods for simplifying it, and at the same time increasing its reliable sensitivity. There are probably more modifications of the Wassermann technic than any other single laboratory procedure, and the very multiplicity of methods has brought in much confusion. For a number of years each laboratory would probably have its own method, no one, the patient the least, profiting thereby. In recent years there has been a definite and widespread effort directed toward the general acceptance of what might be called a standard Wassermann technic. I feel that Dr. Kolmer, of Philadelphia, has distinctly taken the lead in his commendable effort in producing what seems to be a technic most generally applicable to all blood and spinal fluids examined for syphilitic evidence. The technic adopted as standard in my laboratory service is what is known as Kolmer's quantitative Wassermann. It is improbable that any material change or simplification of this test is to be expected any time soon.

Granted that we have acquired a definite and reliable test for the detection of syphilis in this method of Kolmer's, it must be emphasized here that it is not intended that the test be undertaken by anyone other than an experienced technical serologist. There can be nothing more disturbing and disconcerting to physician and surgeon alike than the feeling that he has in hand an unsatisfactory Wassermann report. There has been since the World War a painstaking effort to get around the inherent difficulties of Wassermann work with simpler methods of diagnosis.

*Read before Staff Meeting, St. Luke's Hospital, Jacksonville.

The most promising field of investigation has been found in the study of specific precipitation reactions developed in blood and spinal fluids during the course of syphilitic disease in the patient. The drawback in the general to the adoption of such precipitation studies, either as an additional diagnostic aid or to the exclusion of the Wassermann test entirely, has been until recently either a cumbersome and difficult technic or what is still more important, a wide discrepancy in reports from precipitation tests, and carefully run and checked Wassermann tests upon definitely proven clinical and therapeutic syphilitic or nonsyphilitic cases. The now little known or heard of Meinieke and Sachs-Georgi reactions were the main examples of these early precipitation tests.

In 1907, however, Kahn, Immunologist, State Board of Health of Michigan, brought out an accurately controlled and thoroughly standardized precipitation reaction for syphilis, dependent upon the action of antibodies formed in syphilis upon colloid lipoidal extracts (either alcoholic or cholesterin-fortified) of beef hearts, the value of which has been proven by many different observers in thousands of examinations. No test can be accepted as satisfactory without extensive and searching trial. It seems that the recent adoption of the Kahn test for syphilis by the U. S. Navy, even to the *optional* exclusion of the Wassermann, is the strongest endorsement this test has had. It has in addition been accepted as a standard routine procedure in such State Board of Health Laboratories as those of Kansas and Michigan, Washington University and other laboratories of good reputation. Before giving a summary of the Kolmer and Kahn test, with a demonstration, it would be well to review the limitation and advantage present. For both tests to be evaluated properly, of course, clinical history, signs and symptoms must be considered first and laboratory finding secondarily. There is no infallible serum or precipitation test known. Kolmer in his own series reports above ninety per cent positives by his test in primary syphilis—first four to six weeks; however, many good laboratories fail to detect over fifty per cent strong positives. Twenty per cent of tertiary cases escape, percentage here being decreased by a properly conducted provocative Wassermann test, while secondaries should run nearly one hundred per cent, if no treatment has been had, or if four weeks has passed since discontinuances of a short course of treatment. Imperfect treatment will abolish the Wassermann. In cerebrospinal lues the Wassermann may occasionally fail in the blood serum and be positive in the spinal fluid and vice versa. Kolmer gives the only other known conditions other than syphilis giving positive Wassermann as African Sleeping Sickness, and Yaws, these being excluded from consideration by their rarity in our country.

The above general information is more or less common knowledge. Of more practical importance in daily work are the following facts: a dirty tube will in all probability give a so-called anticomplementary reaction. The anticomplementary reaction is a poorly understood phenomenon at the best and I only mention it here to state that it is practically exclusively due to bacterial contamination of the specimen either by bacterial infection of the patient's specimen in life or in vitro. The only remedy is to throw out the blood and to run a new test. If the tube has been soiled with an acid substance there is a great possibility of getting a negative Wassermann report, even though the patient is a known syphilitic. If the tube is soiled by alkali (even a tube improperly washed with soap and water) it may contain sufficient alkali to render a positive reaction, even though the patient is known to be non-syphilitic. The ingestion of a meal composed largely of fatty foods shortly before the blood is drawn for the test will in most instances simulate a positive reaction. The following drugs have been accused of causing a positive Wassermann test, to-wit: chloroform, ether, amyl nitrate, morphine, codeine, strychnine and cocaine, but have been found by recent investigation to have no effect upon the Wassermann properly conducted. A blood drawn after an alcoholic debauche will invariably simulate a negative reaction in a known syphilitic specimen. Occasionally hyperpyrexic states give an unsatisfactory Wassermann test. It is not hoped or proposed that the Kahn test eliminates all these perplexing difficulties. However, it has been shown that the Kahn test is of distinctively more value than the well-conducted Wassermann in the following circumstances: It is more sensitive in partially treated cases, it is less subject to anticomplementary disturbances, it is reliable in high febrile states, it is slightly more sensitive in congenital syphilis and considerably more sensitive in latent types of disease. In addition, its obvious advantages are relative simplicity of procedure, rapidity of reading, reduc-

tion of error through elimination of the hemolytic system required for any Wassermann, and finally its elimination of all but two reagents and the patient's serum as contrasted to the five reagents and the patient's serum required in Wassermann work. A recent series of thirty-five thousand Kahns done in the Michigan laboratories after careful recheck gives a disagreement with the carefully run Wassermann only once in four thousand times.

In connection with this review of the Kahn and Kolmer tests there has been run this week a simultaneous Kahn and Kolmer test upon each service case in this hospital and upon the cases now in the County Hospital wards—excluding most of the children patients and all recently operated and obviously critically ill and weakened cases. It is not the purpose of this paper to go into the analysis of this group of reactions in these cases, the series of approximately one hundred cases being too small for such a purpose. With the accumulation of an extensive series of this type of comparative tests, such a report may be of value at a later date.

The proposed improvement, then, is the advocation of running a simultaneous Kolmer and Kahn test upon all bloods and spinal fluids presented for laboratory diagnosis of syphilis. This proposal is not impracticable due to the fact that as little as 5 c.c. of specimen can give both tests. The tests can be run simultaneously, and reports made the same day, the one test forming a good check upon the other.

I take this opportunity to express appreciation to the Hospital Staff and to the Board of the Duval County Hospital for the opportunity of carrying on this work, and acknowledge the assistance of my laboratorian, Miss D. P. Allen, and associate, Mr. E. W. Moore, for a large part of technical preparation of this paper.

The demonstration of Kolmer and Kahn tests, varying from negative through strongly positive reactions, will now be made.

PLICECTOMY

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Pensacola.

To the casual observer, it would seem that the removal of the plica or the alternative of leaving it in situ, is a rather uninteresting and unimportant entity. But studies along this line will reveal that the subject is neither uninteresting nor unimportant, for it involves many details, even to derogatory criticism for the ability of the operator. A thousand operations make, or should make, the operator a thousand times more careful as to his end results.

The chief reason that the attention of laryngologists has been turned to the plica is the fact that many patients have had sore throat after a complete removal of the tonsils, which, on examination, proved to be an infection of lymphoid tissue at the base of the tonsillar fossa, which tissue was greatly hypertrophied. Lucky is the man who has his patients return to him for this condition and not to another laryngologist, who, perhaps innocently enough, invariably informs the patient that there is a piece of the tonsil left, for which the physician who operated is blamed and even criticised, when he is innocent of any of the charges. The ancients knew of the removal of "Tonsillar Stumps," for Borelli, an Italian surgeon of Sardinia, describing the finger method of tonsil dissection, said: "A small piece which does not afford sufficient purchase to the finger, in order to be torn away, is generally left at the inferior part." Undoubtedly this was the plica.

EMBRYOLOGICAL ANATOMY.

In the embryo at eight months the form of the tonsil is fairly constant. At this time the tonsil does not project beyond the surface and is covered anteriorly by fold called the Plica Triangularis, or Operculum. This fold divides a little above its middle into two distinct branches, one running anteriorly to the tongue called the plica pretonsillaris, and another running posteriorly passing around the base of the tonsil analage called the plica infratonsillaris. The plica triangularis may remain rudimentary or develop so as to cover, to a greater or less extent, the anterior portion of the tonsil. An important peculiarity of the plica triangularis is that in the fully developed tonsil it is attached firmly to the tonsillar mass only close to its edge, and can readily be separated from the capsule which covers the front of the tonsil.

The anatomy of the plica as seen in the fully developed tonsil is as follows: It is a thin triangular fold of mucous membrane which passes backwards from the posterior surface of the glosso-palatine arch. Its base corresponds to the glosso-palatine arch, its superior border is free and passes downwards and backwards, frequently overlapping the tonsil. Its lower border

is attached to the side of the tongue. It covers, medially, the inferior part of the tonsillar fossa. In some cases the plica is fused with the free surface of the tonsil and the lymph tissue may, in some cases, be developed on the medial surface of that plica.

Tonsillectomy does not, by any method, remove the plica. Plicectomy is a separate procedure and a fairly simple one. After the tonsils have been well enucleated, it is very easy to pick up the plica and its lymphoid tissue in an Allis forceps, or other suitable grasping forceps, previously passed through a snare, and with slight traction pull out the plica and snare it off.

A series of cases was done in which unilateral plicectomy was performed, and, in the majority, it was astounding to see the difference in the appearance of the two fossæ on the following day. In the one where the plica was left it invariably appeared to contain a remnant of tonsil tissue. This of course was due to hypertrophy of the lymphoid tissue of the plica, and it is this tissue which is the cause of any future trouble.

Of course there are contraindications to removal of the plica, but not enough to warrant the neglect of the subject. The chief objection to its removal is in those who use the voice a great deal, such as singers and public speakers, for plicectomy does cause some relaxation of the throat, as it releases the insertion of a few fibres of the constrictor muscles of the pharynx. However most of the cases of injury to the voice have probably been due to the tonsil stumps which were left, and which hindered the mobility of muscular action, or to injury of the pillars themselves. There is also slight bleeding sometimes, but rarely is it more than that from the fossa above. Its control is the same as in the tonsil fossa.

The author has had occasion to converse on the subject of plicectomy with laryngologists in various sections of this country, and the concensus of opinion is favorable to the removal of the plica.

NOTES ON ROSEOLA INFANTUM

NATHANIEL L. SPENGLER, M.D.,
Tampa.

A report of ten cases occurring in my practice in the past two years:

This disease is described under several different names, Exanthem Subitum, The Critical Preeruptive Fever and Roseola Infantum.

The name Roseola Infantum was suggested by Zahorsky, who was the first man to describe it as a separate disease entity. Since that time Zahorsky has writeen two papers and reported many cases. His first paper was published in 1910. Since that time case reports have come from all sections of America and abroad, showing the disease to be one of broad distribution.

Until Zahorsky outlined the symptoms and later Veeder and Hempleman demonstrated the typical blood picture of Lymphocitosis and Lukopenia, this disease was buried in a mass of dermatological literature, where it did not belong.

Etiology—Unknown, non-communicable.

Seasonal Incidence—Occurs during all seasons.

Age—Six months to three years.

Incubation Period—Unknown.

Symptoms—The onset is abrupt, and the symptoms are ushered in by a temperature ranging from 100 to 105 F., lasting from three to five days. During this time the patient does not seem to be very ill. Some may have convulsions due to the high temperature. About the fourth day the palpebral and orbital conjunctive are injected, throat shows varying degrees of redness. Ears are negative. About this time a roseola-like rash appears on the trunk and its intensity diminishes toward the distal end of extremities. At the time of appearance of rash, temperature drops to normal and convalescence is normal. Glandular enlargement has not been noted in my cases, though some authors have reported this finding. The rash rapidly disappears and does not leave any pigmentation.

Laboratory Findings — Lymphocytosis and Lukopenia. Leukocytes run as low as 4,000, while in younger children under one year it would be twice this many or about 8,000 per c.m.

Prognosis—No complications were observed, recovery was rapid and complete.

This disease must be differentiated from scarlet fever, measles, rubella, variola and influenza. Little trouble will be experienced after the rash appears, it is during the febrile stage that the greatest difficulty will be encountered.

I have reported these cases not because it is a new disease but because there is very little literature on the subject, and our text-books have not as yet generally classified this disease among the exanthemata of children.

REPORT OF THREE CASES OF METASTATIC CARCINOMA IN BONY STRUCTURES*

G. Raap, M. D.,
Miami.

In a search of the literature over a period of the past five years, we find relatively few references to the occurrence of carcinomatosis. During the previous five years this subject was frequently written up, but it appears to have become a routine procedure in most of the larger centers to make roentgen examinations of all cases of carcinoma, and the frequency of its occurrence is no longer mathematically studied. In fact I was unable to ascertain in any of the articles written during the past few years, just what the percentage of occurrence is.

The diagnosis of carcinomatous metastases is made easier when there has been a primary malignancy to lead us in the diagnosis, but there are occasional cases in which the primary focus is rather obscure and in which a pathologic fracture or other bone pathology is the first clue. One of the cases I wish to present was of this type.

Carcinoma of the bone is practically always of metastatic origin, and as such is carried to the individual bones by way of the nutrient canals, and consequently is first seen at the middle of the bone or at the point of entry of the blood vessels. One of these cases also illustrates this point. It occurs in two types, most frequently osteoclastic. This is the type usually associated with malignancy of the epithelial type. Here there is no new bone production in the tumor, and on account of the rapid growth of these tumors there is also no external reaction. It grows as a solid mass and destroys all the contingent structures, invading the cortex, medullary canal and adjacent soft structures with equal facility. These cases present a peculiar moth-eaten appearance of the bones involved. In the osteoplastic type there is generalized increased osseous formation. It has been suggested that this takes place through stimulation of preserved osteoblasts, the tumor acting as irritant, or through metaplasia of the fibrous stroma of the tumor. In such cases the differential diagnosis involves that of marble bone disease. A case of this type has been reported by Dr. Lucinian, and I have asked him to bring the photographs of these films for this demonstration.

In the female, we most often find metastases in the ribs and thoracic spine. The element of contingency probably plays some part in making these the most frequent sites. They also occur in the lumbar spine, ilia, femur, skull and humerus. They are rarely found in the forearms or below the knee. Malignancy of the uterus and ovaries only metastasizes to bones in about five per cent of cases and gastric Ca in only about two per cent. Cancers of the mammary gland and of the prostate are most prone to metastasis and in general it may be stated that the less common sites of primary foci are more apt to spread and metastasize in adjacent bones.

The histologic character of the neoplasm in the bone depends largely on the type of primary growth, and very slow growing tumors most often result in osteoplastic secondary metastases. The secondary growths usually occur in those portions of the bone most subjected to pressure or traction. Pathologic fracture in involved bones is not so common as it is in tuberculosis or lues since the tumor tissue usually affords considerable support. Strange to say, fractures are more common in the osteoplastic than in the osteoclastic type.

Mrs. M. S., aged 31, first presented herself at my office on the seventh of August, 1925. She was then under care of Dr. Nichols, who suggested X-ray of her teeth. Her complaint was that of pain in her left shoulder, and since she also had a severe anemia, blood count was ordered.

Red blood cells	2,504,000
Hæmoglobin	50%
W. B. C.	9,675
Color Index	1
Neutrophiles	44%
Eosinophiles	1.5%
Lymphocytes	54%
Large Monos	0.5%

No nucleated reds.

She had been in perfect health until September, 1924, when she had a sudden onset of rheumatic pains in her back, right hip, knee and ankle, and in the muscles of these regions. She made a complete recovery after being in bed off and on for one month. In February, 1925, she began having pains in her left shoulder and elbow, and in May first noticed loss of use of the deltoid and paresthesia in the forearm and fingers. This disuse continued to progress distalward. In February she had considerable nausea and vomiting but no abdominal pain. These symptoms gradually subsided. Films of the teeth at this time were negative for foci of infection. Physical examination showed the deltoid and scapular muscles atrophied and the patient was unable to raise the arm. Pressure over the joint produced definite pain, and passive motion was also painful. There were no areas of an– or hyperæsthesia. The X-ray examination at this time was as follows: There is marked calcium absorption of all the bones in the left shoulder region. It is most marked at the head of the humerus and these changes recede in severity toward the middle of the humerus, the body of the scapula and the acromion process. This rarefaction involves the cortical as well as the medullary portions of the bones, but has left the outline of the cortex still intact, except for a small area on the internal surface just below the neck of the humerus where the cortex has been eroded through. The differentiation lies between an atrophic arthritis and an osteomalacia. It is our opinion that this is an atrophic arthritis since it is apparently localized to this joint and since this patient is of the second age period.

While at my office the patient stated that she had missed her last menstrual period, and since Dr. Nichols had noted in his pelvic examination that the uterus was the size of a four months' pregnancy we thought these bone changes might be due to some calcium metabolism dystrophe. On the 24th of October another pelvis examination indicated no change in the size of the uterus. The possibility of pregnancy was thereby ruled out. In the meantime, I had examined her again and at this time changed my diagnosis to one of carcinomatous metastasis, primary focus probably in the uterus. The patient continued under palliative treatment until December 30, 1925, at which time she went to Pittsburg in the hope of relief, and we expected that the incident would be closed ere long.

On the 14th of July, 1926, Dr. Baker informed me he was attending a Mrs. M. S. and that since I had examined her he would like to have some information as to the X-ray findings. I stated that she could no longer be living, but he proved otherwise by having her brought to my office on the following day. A report of the findings is scarcely necessary. How a human can be alive and have such extensive changes in all the tissues is scarcely conceivable. Strange to say, she is still alive. The mass in the abdomen has increased in size so that she now resembles a pregnancy at full term.

Mrs. E. P. had a total histerectomy at the hands of Dr. Henry Schmits of Chicago about three years ago. Shortly afterwards, bony metastases were noted but the patient was given intensive deep roentgen ray therapy, in heroic doses which at that time were in use, and in which Dr. Schmits was most proficient, since at that time it represented the thought of the German school of radiotherapists. Since that time, although relatively free from symptoms, this patient had lost a full five inches in stature. In February she requested X-ray examination

(*Continued on page 81*)

*Read before Dade County Medical Society Aug., 1926.

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TWELFTH DISTRICT—DR. BAKER WHISNANT . . . *Fort Myers*
Glades, Charlotte, Hendry, Lee, Collier.
THIRTEENTH DISTRICT—DR. R. C. HUBBARD . . . *Tampa*
Hillsborough, Hernando, Pasco.
FOURTEENTH DISTRICT—DR. N. A. BALTZELL . . . *Marianna*
Calhoun, Jackson, Gulf.
FIFTEENTH DISTRICT—DR. JOHN E. HALL . *West Palm Beach*
Palm Beach, Broward.
SIXTEENTH DISTRICT—DR. M. M. HANNUM *Eustis*
Sumter, Lake.
SEVENTEENTH DISTRICT—DR. JOHN S. MCEWAN . *Orlando*
Osceola, Orange.
EIGHTEENTH DISTRICT—DR. S. G. HOLLINGSWORTH . *Bradenton*
Manatee, Sarasota.
NINETEENTH DISTRICT—DR. D. L. MCSWAIN . . . *Arcadia*
DeSoto, Hardee, Highlands.
TWENTIETH DISTRICT—DR. WM. R. WARREN . . . *Key West*
Monroe.
TWENTY-FIRST DISTRICT—DR. ROBT. C. BOOTHE . *Fort Pierce*
St. Lucie, Okeechobee, Indian River, Martin.

FLORIDA HOSPITALS

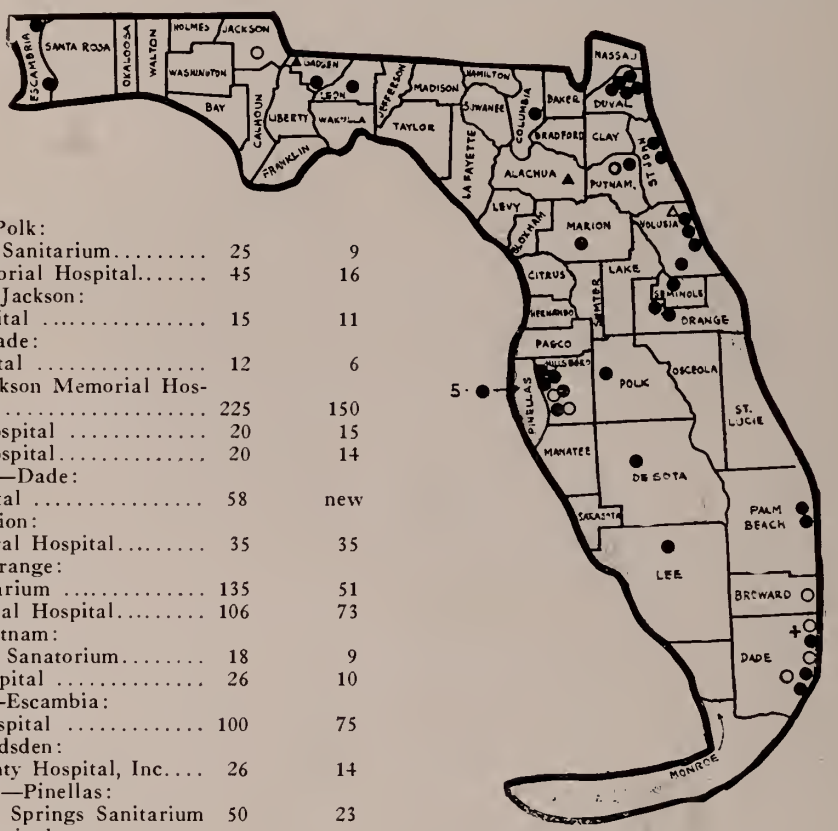
The following data has been compiled by the Council of Medical Education and Hospitals of the American Medical Association in their recent survey of Florida, and appeared in the Hospital number of The Journal of the American Medical Association, April 3, 1926. A comparison of this data with that of former years very aptly illustrates the rapid growth of Florida and the great increase in the number of hospitals supplying both the large and small communities:

	Total Beds.	*Average Beds in Use.*
Arcadia, 3,479—DeSoto:		
Arcadia General Hospital.....	25	15
Century, 1,000—Escambia:		
Century Hospital	20	10
Clearwater, 2,427—Pinellas:		
Morton F. Plant Endowed Hospital	31	16
Daytona, 5,445—Volusia:		
Dr. Bohannon's Hospital and Sanitarium	25	15
Daytona Private Hospital and Sanitarium	20	10
Daytona Beach, 825—Volusia:		
McLeod Hospital	25	17
DeLand, 3,324—Volusia:		

	Total Beds	Average Beds in Use.
DeLand Memorial Hospital	24	10
Ft. Lauderdale, 1,000—Broward:		
Edwards Hospital	25	18
Ft. Myers, 3,678—Lee:		
Robert E. Lee Memorial Hospital.	30	14
Homestead, 1,307—Dade:		
Post-Graduate Hospital	12	6
Jacksonville, 95,450—Duval:		
Brewster Hospital (Colored)	32	27
Duval County Hospital*	110	102
Riverside Hospital, Inc.	35	33
St. Luke's Hospital*	100	88
St. Vincent's Hospital	64	55
Lake City, 3,341—Columbia:		
Lake Shore Hospital	25	9
Lakeland, 7,062—Polk:		
Dr. Causey's Sanitarium	25	9
Morrell Memorial Hospital	45	16
Marianna, 1,915—Jackson:		
Baltzell Hospital	15	11
Miami, 69,754—Dade:		
Gowdy Hospital	12	6
James M. Jackson Memorial Hospital	225	150
Riverview Hospital	20	15
South Side Hospital	20	14
Miami Beach, 644—Dade:		
Allison Hospital	58	new
Ocala, 4,370—Marion:		
Marion General Hospital	35	35
Orlando, 9,257—Orange:		
Florida Sanitarium	135	51
Orange General Hospital	106	73
Palatka, 5,102—Putnam:		
Mary Lawson Sanatorium	18	9
Parkview Hospital	26	10
Pensacola, 25,305—Escambia:		
Pensacola Hospital	100	75
Quincy, 2,540—Gadsden:		
Gadsden County Hospital, Inc.	26	14
Safety Harbor, 429—Pinellas:		
Espiritu Santo Springs Sanitarium	50	23
Sanford, 5,588—Seminole:		
Fernald-Laughton Memorial Hospital	26	10
Sarasota, 840—Sarasota:		
Halton Hospital	10	5
Sarasota Hospital	25	3
St. Augustine, 6,192—St. Johns:		
East Coast Hospital	115	60
Flagler Hospital	100	40
St. Petersburg, 26,847—Pinellas:		
Faith Hospital, Inc.	40	20
Mercy Hospital (Colored)	13	8
Mound Park Hospital	60	48
Tallahassee, 5,637—Leon:		
Johnson's Hospital	25	12
Tampa, 94,743—Hillsboro:		
The Bayside Hospital, Inc.	40	35
Centro Espanol Sanatorium	52	10
Clara Frye Hospital (Colored)	75	35
Dr. H. M. Cook's Sanatorium	47	31
Gordon Keller Memorial Hospital	85	67
Tampa Sanitarium	10	2
West Palm Beach, 8,659—Palm Beach:		
The Good Samaritan Hospital	200	98
Pine Ridge Hospital	30	15
Total for community use, 49	2,472	1,455

In Florida the following thirty counties have no hospitals for community use: Baker, Bay, Bradford, Calhoun, Citrus, Clay, Franklin, Hamilton, Hernando, Holmes, Jefferson, Lafayette, Lake, Levy, Liberty, Madison, Manatee, Monroe, Nassau, Okaloosa, Osceola, Pasco, St. Lucie, Santa Rosa, Sumter, Suwannee, Taylor, Wakulla, Walton, Washington.

Hospitals marked with a star () are approved by the Council on Medical Education and Hospitals for internship or the fifth year in medicine.



•Hospital for community use.
+Tuberculosis Hospital.
▲Nervous and Mental Hospital.
o + _ Established since 1920.

Total hospitals in Florida, 70; for community use, 49; population per hospital bed, 511; percentage of beds occupied, 58; percentage of counties without hospitals, 47.6.

IVY POISONING

How distressing are the symptoms produced by poison ivy, poison oak and poison sumac can best be appreciated by those who have experienced them. Unlike the briers and thistles the injury produced by these plants is not evident for a few hours or days after coming in contact

with them. For this reason it is necessary for those who frequent the woods to familiarize themselves with the appearance of the plants in order that contact may be avoided.

Susceptible persons whose work or play exposes them frequently to the poisonous plants, will be interested in the work of Schamburg and Stickler (*) who report a high degree of immunity secured by injecting extracts from the plants themselves. Solutions of these extracts may be secured and injected by the family physician.

Much of the poison that may have been collected on the skin during an excursion through the swamps and woods may be removed by a thorough bath and vigorous scrubbing with hard water soap—laundry soap—followed by repeated rinsing. Alcohol will remove the poison, but must be used freely if at all, as small quantities will only hasten penetration. Poison may remain on the clothing or shoes and cause trouble long after contact with the plants, hence such articles should also be carefully cleansed before they are worn again. In an article produced for newspapers by Science Service (Washington, D. C.) the value of solutions of iron salts, for preventing and curing the symptoms of ivy poisoning, is set forth. Dr. Jas. B. McNair at the University of Chicago finds that a 5 per cent solution of ferric chloride in 50 per cent alcohol or 50 per cent glycerin is safe and effective as a preventive if applied either before or after an excursion to the woods and as a remedy in the early stages. Dr. Geo. D. Fuller at the same school prefers a strong solution of ferrous sulphate (copperas). A 5 per cent solution in water may be used.

A well-known dermatologist of Jacksonville states that during his childhood a barrel of this solution was kept in a secluded spot on the home place, and used as a dipping vat for those who ventured too near the venomous vines and shrubs and, he says, this was an effective method of treatment.

As one would expect, the resin-like poison of these plants is most likely to be deposited on the exposed parts of the body, particularly the hands. It is often conveyed to the face and other parts as by wiping off perspiration, etc.; therefore, the exposed parts are most frequently affected and this is an important point in recognizing the nature of the itching, burning, blistering and weeping of the skin when they appear from two hours to five days after a trip into the woods.

It is often necessary to call on a physician to make the diagnosis and always desirable to seek his advice regarding treatment.

A valuable bulletin, dealing largely with the recognition and eradication of poison ivy and poison sumac, has been published and may be had by applying to the United States Department of Agriculture, Washington, D. C., for Farmers Bulletin, No. 1166.

(*) Journal of the American Medical Association, January 13, 1917, October 18, 1919, June 2, 1923.

NEWLY ORGANIZED SOCIETIES

The activity in the Florida Medical Association is well evidenced in the recent reorganization of the DeSoto County Medical Society joining with Hardee and Highlands Counties in the formation of a Tri-County Medical Society, at a recent meeting held in Sebring. The doctors of these three counties had a most enthusiastic meeting and elected the following officers: Dr. D. L. McSwain, president; Dr. H. V. Weems, vice-president; Dr. I. W. Chandler, secretary-treasurer.

Last month, the counties of St. Lucie, Okeechobee, Indian River and Martin met at Ft. Pierce and organized a Four-County Medical Society, electing the following officers: Dr. H. C. McDermid, president; Dr. J. W. Bishop, vice-president, and Dr. G. C. Hardie, secretary.

The organization of these two societies brings into the Association organized medicine in the following new counties: Hardee, Highlands and Martin. By means of consolidating small county societies, better programs can be arranged, as well as larger attendance obtained. It is with pleasure that the Association welcomes the newly organized Tri-County and Four-County Medical Societies into its fold.

STATE NEWS ITEMS

The Duval County Tuberculosis Association have opened a new children's hospital in Jacksonville, which is known as Hope Haven. A full description and account will appear in next month's Journal.

Dr. A. R. Knauf and Dr. C. A. Andrews of Tampa have just returned from a visit to Rochester and Chicago where they attended clinics.

Manatee County Medical Society is growing very rapidly, its present membership being twenty-four. They have continued their meetings during the summer season with excellent attendance. The treasurer of the Association announces with pleasure that this is a 100 per cent Society.

The Palm Beach County Medical Society, at a recent meeting, unanimously adopted a set of resolutions to be presented to the Board of Governors of the Good Samaritan Hospital of West Palm Beach, calling for a complete reorganization of the staff of the institution. The proposed plan of reorganization is in accordance with an outline submitted by Dr. Frank Billings, of Chicago, and if adopted by the Board of Governors, should result in a material betterment in the management of the hospital. Dr. Leon Ashley Peek was nominated chief of staff, Dr. George M. Dawson, director of surgery, and Dr. R. O. Cooley, chief of the medical service.

Dr. E. F. Carter announces the removal of his office from the Stovall building to 1719 Grand Central Avenue, Tampa, Florida.

The Nurses' Training School of the Arcadia General Hospital held its second commencement exercises Wednesday evening, August 18th. The graduating class was composed of three young ladies—Misses Virginia Welch, Thelma Hammons, and Maud Summersill.

The resumption of meetings of the Escambia County Medical Society occurs September ninth with Dr. H. Mason Smith, president of the Florida Medical Association, as guest of honor.

CONGRATULATIONS TO MONROE COUNTY MEDICAL SOCIETY. DUES OF ALL MEMBERS 100% PAID. SEE SCHEDULE ON PAGE 82. WATCH THE NEWS COLUMN FOR THE NEXT SOCIETY TO REACH 100%.

The Palm Beach County Medical Society is making active preparations toward the perfection of the program of entertainment of the coming State Medical Association meeting, and it trusts that the meeting may be a memorable one, not only from a scientific but also from a social standpoint.

Dr. John A. Simmons of Miami was a recent visitor to Arcadia.

Dr. A. M. Bidwell announces the opening of his new offices at 411-13 First National Bank Building, Tampa, Florida.

A dinner was given during the past month by the Monroe County Medical Society in honor of Dr. G. M. Guiteras. Dr. Guiteras recently returned to Key West as surgeon in charge of the Marine Hospital, relieving Dr. M. K. Gwyn who has been assigned to duty at Astoria, Oregon. Dr. Guiteras formerly lived in Key West and the members of the Monroe County Medical Society expressed to him, through the medium of this dinner, their great appreciation in having him return. The following is a copy of their menu:

MENU

Special ℞ a la Dr. Galey
President Monroe County Medical Society
Entree a la Dr. Plummer
Secretary-Treasurer Monroe County Medical Society
Sopa Tartara a la Dr. Warren
Key West Fish a la Dr. Porter, Senior
Arroz con Pollo a la Dr. Guiteras
Bella Donna Salad a la Dr. Keating
Flan de Leche a la Dr. Lowe
Figs (California Syrup) a la Dr. Porter, Jr.
Cafe Cubano a la Dr. Pintado
Cigars a la Dr. Little
Plus- Sorpresa a la Dr. Rodriguez

Dr. C. C. Webb of Pensacola recently left for New Orleans for the Annual Lipton Cup races of the Southern Yachting Association.

Dr. C. J. Heinberg of Pensacola will go to Chicago in September for a few weeks' clinical work.

Dr. W. M. Rowlett, of Tampa, our genial secretary of the State Board of Medical Examiners, was at West Palm Beach and Lake Worth on August 28th, investigating the license of an alleged illegal practitioner of medicine at Lake Worth. The Palm Beach County Medical Society gave a dinner in his honor at the Monterey Hotel. Dr. Rowlett delivered an interesting address relative to organized medicine and the

necessity for the inauguration of drastic laws dealing with the illegal practice of medicine in Florida.

Dr. Julien C. Pate announces the removal of his offices from 210-212 Hensley-Stovall Arcade building to 1107-1109 First National Bank Building, Tampa.

Dr. J. H. Bickerstaff of Pensacola is contemplating a trip to Vienna shortly.

On Thursday evening, August 28, 1926, in response to notices mailed out by Dr. H. Mason Smith, president of the Florida Medical Association, a large number of doctors from Lakeland, Tampa and surrounding towns assembled in the parlors of the Hotel Sebring after a delightful dinner served by the Sebring doctors.

The meeting was called to order by Doctor Herman Watson of Lakeland. Dr. Smith was introduced and delivered a snappy and enthusiastic address on organized medicine. Dr. Smith said: "Organized medicine always precedes civilization and has made possible the Panama Canal; has made it possible for Florida to be as it is today—a playground for America. A medical bill is now being drafted with the help of the State Board of Health which will take away from all men now using the term 'M.D.' unless they are bona fide graduates of medicine."

Dr. Smith denounced contract practice in all of its phases and pointed out facts showing that "unless this practice is discontinued by members of the profession, we will soon be not scientific men, but employees of the large industrial corporations, working for a small salary with no incentive to give to our patients the best in us. This will strangle our desire to keep medicine on the high and unselfish plane it has occupied since the days of Hypocrates. Florida today has as good men as the country affords, doing all classes of work." He pointed to Dr. Kirby-Smith as a man who has attained an international reputation from his work on Larva Migrans. Instances were cited of where in our own as well as in many foreign countries, men are doing major operations for the sum of $10.00 to $12.00 and medical men caring for whole families for a few dollars each month.

It was gratifying to hear our president state the Florida Medical Association is out of debt after liquidating a $3,000 debt and now has a goodly sum in the treasury.

The following officers were elected: Dr. D. L. McSwain, president; Dr. H. V. Weems, vice-president; Dr. L. W. Chandler, secretary-treasurer. Councillors: Dr. C. H. Kirkpatrick, DeSoto, 3 years; Dr. J. E. Garner, Hardee, 2 years; Dr. J. W. Mitchell, Highland, 1 year.

Polk County Medical Society held its regular meeting at Lakeland August 12, 1926, at the Cleveland Heights Country Club. The guests for the evening were the members of the Hillsborough County Medical Society. The guest of honor was Dr. J. Lee Kirby-Smith of Jacksonville, and Dr. H. Mason Smith of Tampa, President of the Florida Medical Association. Dr. R. L. Kline, president of Polk County Medical Society, was master of ceremonies. Music was furnished by an orchestra with several vocal solos by local talent, and a few banjo solos. Everyone present was requested to rise and introduce himself. Dinner was then served and Dr. H. Mason Smith was introduced. Dr. Smith stated that organized medicine was on a higher plane today than ever before, but did not go into details of progress and proposed improvements in the organization, and conceded the floor to Dr. Kirby-Smith, the guest of honor and chief essayist of the evening. Dr. Kirby-Smith prefaced his remarks by giving a geographical distribution of Larvæ Migrans, showing this not to be a Florida disease but one found along the entire Atlantic seaboard and gulf coast, extending beyond the Mississippi as far as the Texas border. A line drawn from the mouth of the Mississippi river to the uppermost part of the Atlantic seaboard would embrace the entire southeast. Sporadic cases are sometimes seen above this line, and when this disease becomes better known, no doubt many cases will be found in other sections of America. These remarks were followed by numerous lantern slides showing the most probable places of obtaining infection, and the disease in all stages of development. This was followed by the symptoms, prophylaxis and treatment of disease. At the close of the essay, Dr. Kirby-Smith invited all present to ask any questions they wished. Many questions were asked, showing a lot of interest and appreciation of the work done by Dr. Kirby-Smith in the study of Larva Migrans. To gain the information given by Dr. Kirby-Smith entailed an enormous

amount of time and he should have full credit, from the world at large where this disease occurs. Florida should be proud to call Dr. Kirby-Smith a native son, and the medical profession should be stimulated by his efforts in original research work and carry on this research as well as research along other lines.

STATE BOARD OF HEALTH NOTES

HELP WANTED

We wish to stamp out diphtheria and we ask every physician in the State to serve as a committee of one to see that each child under his care is protected. Every child from six months to six years should be given toxin-antitoxin without a preliminary test. Older children should be given a Schick test to determine which of them need the T-A and this needs a large group such as a school, for the smallest test package is for fifty tests. As the greatest susceptibility is among those under five, this age group has been the one in which the great majority of fatalities has occurred.

Last year there were 105 deaths from this disease—105 needless deaths—and if each of us will see that each one of the children, entrusted to our care, is immune we can stamp out this disease and do it promptly, too.

During September and October there will be a continent-wide campaign against this disease and we ask for your cooperation.

Did you read your copy of Health Notes? We would welcome any suggestions as to means by which it can better put across its message.

Every month we receive certificates showing that death occurred from a reportable disease. Each of these is checked to find if the case has been reported and if it has not been a report is requested.

It is embarrassing to us to be obliged to make such a request and we trust you will save us from further need along this line.

No matter if there has been a former physician, you should report each case of a notifiable disease, and if it has been reported previously your report will be marked duplicate, but if there is no previous report it will save embarrassment in case the patient does not recover.

THE ANNUAL HEALTH EXAMINATION

The general public is being educated gradually to the importance of going once a year to the doctor for a physical examination. Some physicians, when requested to make such an examination, look at the tongue, feel the pulse, smile a knowing smile and say, "Oh, you are as sound as a dollar." The client goes away wondering if he has received the value of the small fee asked. Other physicians strip the candidate, make a careful physical examination, inspect the orifices, take the blood pressure, test the urine, blood, etc., refer him to specialists if necessary, collect a worth-while fee and send him away rejoicing in the thought that he has paid a good price but got his money's worth.

Failure to furnish healthful surroundings is the only possible condition that can prevent the steady, sure and rapid development of this State.

The medical profession is therefore in position to render a vast service to the State and we ask for the fullest cooperation that each case of communicable disease is promptly reported, that an insanitary condition is corrected and that the value of immunity is made clear at every opportunity.

The time will soon come when a case of diphtheria in a family under the care of a physician will be considered a reflection on that physician unless he can convince the public that he had tried to convince that family that no one need have diphtheria, for they could avoid it so easily.

We are trying to cut our diphtheria incidence by a continent-wide campaign and you can get the toxin antitoxin by asking for it. If each physician will make it a habit to give toxin antitoxin to every child he treats between the ages of six months and six years, we can soon have a population that is practically immune to diphtheria.

Is not this a goal worth striving for.

Dr. M. T. MacAvelia, recently of Ft. Myers, has been appointed Field Medical Officer to succeed Dr. W. A. Claxton in the lower East Coast District. Dr. MacAvelia saw military service during the world war, and has had experience in Public Health Work.

Dr. Chas. W. Pease, newly appointed Medical Officer in the Tampa District, reported at the Jacksonville Office August 25th for instruction, and is now busily engaged in acquainting him-

self with his territory, investigating communicable disease conditions, and preparing for a campaign of immunization.

With the opening of the schools comes an increased incidence of children's diseases and a greater need as well as a better opportunity for effective control measures. Physicians are earnestly requested to be prompt about reporting every case, isolating the patient and instructing attendants as to precautions that should be taken. Prompt action will prevent sickness and save precious lives. The cooperation of the medical profession, so necessary to successful health work, is greatly desired and appreciated.

THE PRACTITIONER'S PART

The annual conference of State and Provincial Health Officials was held at Atlantic City in May. A resolution adopted by this body proposes that special attention be given to prevention of Communicable Diseases during the first six months of the school year.

September and October are set apart for diphtheria prevention.

November and December for smallpox.

January and February for typhoid.

It is not the duty of the health official only to promote health and prevent sickness. There are 1625 doctors in Florida, some are part time, poorly paid health officers or physicians for county or city, most are just practitioners, but every one has a responsibility he cannot and would not evade. Each will perform his duty to the best of his ability.

Every child under school age should have T-A immunization. Children of school age should be Schick tested and treatment given to the reactors only.

Every one should be successfully vaccinated against smallpox, and revaccinated every five years.

Typhoid shots should be given every three or four years.

ADVERTISERS' NOTES

ANTITOXIN UP TO DATE

Ever since the discovery of diphtheria antitoxin, biological manufacturers have been endeavoring to overcome certain difficulties associated with its use. One of these, the bulk of the effective dose, has been disposed of by elimination of the water and other non-essential elements, until a product approaching a state of absolute purity has resulted. The best antitoxin, while small in bulk, is sufficiently fluid to ensure prompt absorption and consequently prompt therapeutic effect.

Another difficulty has been that the rubber of the plunger in the syringe packages in which all antitoxins are supplied is very apt to become adherent to the glass barrel of the syringe, and physicians have had no end of trouble in trying to break the adhesions without breaking the syringe.

Parke, Davis & Co., as will be noted by reference to their advertisement elsewhere in this issue, offer not only a highly concentrated antitoxin with low protein content, but an "improved" syringe package. We understand that the improvement consists principally in an ingenious reduction of the area of contact surface between the plunger and the syringe barrel, so that by giving the piston rod a gentle turn the plunger can be rotated and then, of course, moved forward under steady pressure.

MEETING EMERGENCIES

Associated with many present-day emergencies in which the health of a community is concerned, in which, perhaps, the lives of many persons are in jeopardy, are hurry calls from physicians for biological products.

The discovery of smallpox in a neighborhood and vaccination by the wholesale; an explosion, such as occurred at Lake Denmark, N. J., where the possibility of many cases of tetanus threatened; an outbreak of diphtheria in a school or community; a mad dog scare—all these are emergencies in meeting which the medical profession is depending more and more upon the administration of biological products.

Through its depots that are being opened in various cities throughout the United States, the House of Squibb is providing sources of supply for arsphenamines, insulin and biological products, kept under proper refrigeration and quickly available at any hour to the physicians and the pharmacists of the respective neighborhoods.

Thus far depots have been established as follows:

New Orleans, La., Depot at 402 Queen and Crescent Building, 344 Camp Street, Telephone, day, Main 8636; night, Walnut 4392-J.

Pittsburgh, Pa., Depot at 604 Maloney Building, 339 Second Avenue, Telephone, Court 1220.

Minneapolis, Minn., Depot at 237 Transportation Building, 317 Second Avenue, South Telephone, day, Geneva 3248; night, South 8716.

Seattle, Wash., Depot at 216-217 Crary Building, Fifth and Union Streets, Telephone, Elliott 1878.

Baltimore, Md., Depot at 1027 Munsey Building, 5 North Calvert Street, Telephone, Calvert 4308.

ELECTED PRESIDENT AMERICAN PHARMACEUTICAL MANUFACTURERS' ASSOCIATION

The American Pharmaceutical Manufacturers' Association at its annual June meeting at Lake Placid, New York, did itself the honor to elect Ralph R. Patch president. Mr. Patch is the president and general manager of the E. L. Patch Co. of Boston, Mass., the well-known manufacturers of Patch's Flavored Cod Liver Oil.

The American Pharmaceutical Manufacturers' Association comprises the large manufacturers of preparations so extensively used by the medical profession; and physicians are therefore interested in the personality of its officers. Mr. Patch has served the Association for several years as its Secretary-Treasurer, and his election as president came as a fitting reward for his years of service in behalf of that organization.

REPORT OF THREE CASES OF METASTATIC CARCINOMA IN BONY STRUCTURES

(*Continued from page 73*)

for pain in her back from her shoulders down to her buttocks. These films show areas of rarefaction, but you will note that they have concentric rings of calcium deposit which represent the courses of treatment, and are probably due to temporary arrest of the growth of these tumors.

Mrs. D. M. W. had a radical breast amputation on July the tenth, having had a palpable mass in the right breast for ten years which during the previous six months had been breaking down. With a view toward post-operative radiation, Rr. Hall requested me to see her about ten days later. At that time she had severe pain in her lumbar spine and we thought it wise to ascertain the cause of this symptom before proceeding with the radiation therapy. Examination on the thirtieth of July shows the moth-eaten appearance of the right halves of the first and second lumbar vertebrae, characteristic of metastatic carcinoma.

The Southeastern Sanatorium

418 Capitol Avenue, S. E., Atlanta, Ga.

Old Number 172 Capitol Avenue

For Mild Mental and Nervous Diseases, Alcoholic and Drug Addictions.

Located in the central residential district of Atlanta, on street car line and 5 minutes from railway terminals.

Thirty rooms en suite or single with private lavatory, toilet, private bath.

Quiet and homelike atmosphere; refined nurses and excellent cuisine.

Every patient receives the maximum of individual attention.

Completely equipped for Physic, Hydro and Thermo Therapy; deep X-Ray Therapy if indicated.

Rates and reservations furnished on application.

GEO. S. PITCHER, M.D., Director.
W. A. GARDNER, M.D., Medical Director.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

County Society	MEETINGS					Dues Paid
	Secretary	Date	Time	Place	Luncheon?	
Alachua	W. Lassiter, M.D., Gainesville.					70%
Bay	J. M. Nixon, M.D., Panama City.					100%
Bradford	Seeber King, M.D., Lake Butler.					100%
Brevard	R. D. Ferguson, M.D., Titusville.	Varies		Varies		100%
Broward	Leigh F. Robinson, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Commerce	No.	100%
Columbia	L. J. Arnold, M.D., Lake City.					82%
Dade	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.	82%
Duval	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.	100%
Escambia	Herbert D. Snyder, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	66%
Four Counties	G. C. Hardie, M.D., Ft. Pierce.					43%
Hillsboro	B. W. Lowry, M.D., Tampa.	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.	96%
Jackson	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.	96%
Lake	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	93%
Manatee	J. M. Davis, M.D., Bradenton.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.	90%
Monroe	G. R. Plummer, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	95%
Palm Beach	W. O. Arnold, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Monterey Hotel	Yes.	100%
Pasco-Hernando	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.	91%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every 2nd Friday	8:00 P.M.	Fla. Art School	No.	99%
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	89%
St. Johns	I. M. Hay, M.D., St. Augustine.	3rd Monday	8:30 P.M.	Varies	Yes.	91%
Sarasota	F. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Second District County Medical Society	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	88%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	86%
Taylor	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	78%
Tri-County	I. W. Chandler, M.D., Avon Park.		8:00 P.M.	Varies	No.	81%
Volusia	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	88%
Walton	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	88%

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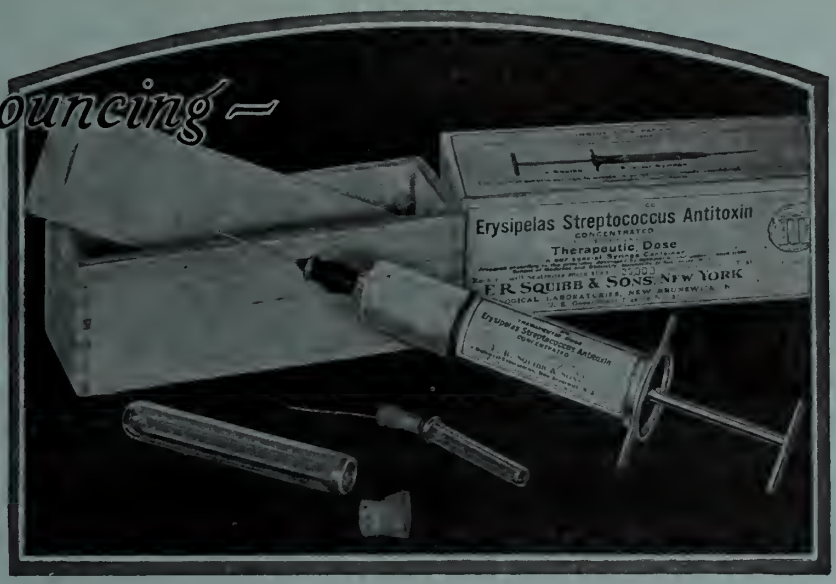
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— OF THE —
Florida Medical Association

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CONTENTS

	PAGE
The Outlook in Diabetic Children — *Louie Limbaugh, M.D., Jacksonville.*	83
Mercurochrome in the Treatment of Septicæmia of Mastoid Origin — *T. H. Odeneal, M.D., W. Palm Beach.*	86
Squint — *Shaler Richardson, M.D., F.A.C.S., Jacksonville.*	89
Fractures of the Shaft of the Femur Treated by Traction — *F. L. Fort, M.D., Jacksonville.*	91
Lead Poisoning in Children — *L. W. Holloway, M.D., Jacksonville.*	94
Editorials: (1) Harvest Mites or Red Bugs; (2) Where is Florida's Blind Baby?	97, 98
State News Items	98
Advertisers' Notes	100
Schedule of Meetings—Component Societies Florida Medical Association	101

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THE OUTLOOK IN DIABETIC CHILDREN*

LOUIE LIMBAUGH, M.D.,
Jacksonville.

The purpose of this paper is not to attempt a prognosis of diabetes occurring in children, but rather to discuss some phases of the influence of the disease on the individual who has not yet reached adult life.

Certainly since the advent of insulin the diabetic child has a road to travel far diverged from a similar sufferer of ten years ago. Then, from the figures of Von Noordan, the average length of life of a diabetic in the first decade was two years, and boys or girls in their 'teens had an average expectancy of but four years. That the time limit has been materially extended is even now realized. Diabetes has made less inroads into the vitality and development of the vast majority of afflicted children in the past three years than in any such period before. The future should hold the same outlook for new cases. Can careful dietary, proper hygiene and insulin continue to do as much in the next three years as it has so far in treated cases?

One cannot but realize that Banting did more than just give a substance which would oxidize carbohydrates when he gave the world insulin. It is a life buoy to diabetic children, but the rope that pulls the endangered struggler to shore is the physician's knowledge of dietary indications. Since the use of the drug is so importantly imposed upon food values, there can be little doubt but that the diabetic child of today is getting a far more normal and natural diet than ever before. His protein intake is and must be as carefully estimated as the carbohydrate and fat. Hence body development and growth can and does well approach that of the normal and healthy child. So that insulin has caused, as well as allowed, a diet carefully planned to meet the needs of each individual case. It has stressed the necessity of an accurately measured diet and thus has broadcast dietary knowledge. Many diabetics can be controlled by diet and no insulin; no one would treat a case with insulin and no dietary measures.

There are many factors which might influence the outlook of diabetes in a child. Usually, a more severe form of the disease is seen in younger people and its control may tax one to the limit.

Heredity is said to have a bearing. In many cases there is no positive family history, but when such exists there is a tendency, as quoted by Mosenthal, for the disease to develop at an earlier age in each successive generation. In this connection, it is interesting and informing to note that Joslin considers heredity a favorable occurrence because in his experience these cases are not infrequently mild, and he further considers that the younger the child when the disease manifests itself, the better the outlook.

Obesity or overweight in children probably plays less part as a causative factor of diabetes than in adults, but it would be advantageous to the future welfare of a diabetic child to so arrange a diet which would allow normal growth, strength and activities, and yet keep it well within the average weight for its age, sex and height.

Infections play an important role in the course of a diabetic life; and this, aside from the skin infections and carbuncles which may occur as complications. Concurring infectious diseases, severe colds, tonsilitis, or relatively minor infections, such as abscessed teeth, may markedly lower the patient's tolerance after a satisfactory balance between diet and insulin has been long established. Such a lowered tolerance may persist. All children should of course be guarded against infections, but especially so the diabetic child.

What influence the catamenia may have is questionable. It is not believed that the disease diabetes per se would influence the onset or regularity of the menstrual cycle as long as undernutrition was not allowed to exist. The writer has had one case under observation for the past three years who is now thirteen years of age and who is rapidly showing the body developments of puberty. This girl contracted mumps about one year ago and has never regained her lost tolerance, but on the contrary is with difficulty

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

kept within normal blood sugar limits. An experience with another case of a woman aged thirty-eight, who with regularity has a complete loss of tolerance for a week prior to the onset of each mensis and who invariably regains her tolerance the day the flow begins, has led to thoughts that perhaps the developing girl referred to will gain back some of her tolerance with the ushering in of her menstrual functions. Pituitary and suprarenal gland activities diminish glucose tolerance as well as does thyroid over-activity. Does the known relation between thyroid and ovarian endocrines play a part in the disturbances mentioned? Pregnancy might be discussed at this time, for these growing girls in their 'teens may well be hoped to successfully check the progressiveness of diabetes and live to consider wifehood and motherhood. The latter is generally considered to be contra-indicated, though the writer had the pleasure of seeing a happy mother and her eight- or nine-year-old lusty lad when visiting Joslin's Clinic last year. This mother had had diabetes for some years prior to the birth of her child.

One of the most common complications of diabetes is arteriosclerosis. This statement does not refer to children, of course, but if they should live to the fourth decade we may see more arteriosclerotic complications than we see today. Certainly we should guard against such development. It may be that years of careful dieting will prevent such changes, though at best a diabetic diet must vary from the accepted normal body needs. Prevention of those things which make a patient susceptible to gangrene should be instilled in the minds of our youthful diabetics. And as time goes on we shall perhaps immortalize Joslin's statement that "individuals over fifty years of age must learn to keep their feet as clean as their faces."

It is not felt that case reports would be of any especial interest at this time. There have been observed and treated seven patients under twenty-one years of age in the past three years. Their ages were, when first seen, four, eight, ten, thirteen, fifteen, sixteen and eighteen years, respectively. All cases have shown satisfactory growth and development and all have presented difficult problems from time to time. The case least controlled at present is the girl referred to earlier, though her general appearance would indicate in no manner that she was other than a normal, healthy school girl, and her activities in work and play parallel her brothers and sisters. None of the cases give a history of heredity, though the two patients, aged 15 and 16, respectively, are sisters.

In concluding, one must say that at least the outlook in the diabetic child of today is far more cheerful than ever before.

DISCUSSION

Dr. W. C. Thomas, Gainesville, Fla.:

When I get a case of diabetes I generally send it to Dr. Limbaugh or Dr. Harris in Jacksonville. But we all meet with cases of diabetes and we cannot always send them away.

I am not as interested in diabetes as Dr. Limbaugh. We were internes together and I remember how he used to follow the doctors around the wards in the hospital, and run diets, etc. That was before very much was accomplished with diabetes and what had been accomplished was due to following Allen's leadership. Now, since we have insulin, we have a really valuable vehicle.

Joslin, in reporting something over three hundred cases of diabetes, states that of something over 150 cases in a three-year period before insulin came in, twelve were living at the end of two and one-half years, and of one hundred sixty cases under treatment since insulin came in, one hundred and fifty are living. When you stop and think about it, it is really a remarkable change.

As Dr. Limbaugh said, insulin cannot be used without diet. We cannot diet a child like we can an adult. We have to give the child enough nourishment. When you figure out the actual proportion of food that they have to have, 1.25 grams to produce a kilogram of weight, they have to have fats and carbohydrates to help oxidize these fats. Acidosis does not come from carbohydrates, but does come from fats. In figuring out the food requirements in feeding the child, we feel that these requirements are best taken care of with the use of insulin. Frequently insulin can be lowered and sometimes it has to be raised. It is very important to find out just how and when to give it.

I had a little child several months ago. She brought in a specimen of morning urine for several days, but I did not get anything but a slight amount of albumin. I told her she would have to bring in a twenty-four-hour specimen. As soon as she did, the diagnosis was made and I promptly got rid of her; sent her to someone else for the simple reason that we could not do blood

sugars here. Lots of men do that now and lots of men use insulin without controlling the blood pressure. I personally do not advocate that course, but we may be placed where we cannot get it. Now, we are near Jacksonville and send our children there for study. Of course, an overdose of insulin is easily controlled by a little sugar or a little orange juice.

Dr. Joslin, in reporting the series of cases I have just mentioned, states that he has not had a single case of a young girl developing the menstrual function before the use of insulin, but had four cases under treatment before they had developed the menstrual function and a number of boys who had developed up through what he considered puberty.

Dr. Limbaugh mentioned the case of a woman giving birth to a child. I believe that if I had a patient I would not want her to go through pregnancy. We don't know quite enough about what will be the outcome of this. We do know that arteriosclerosis is an important factor in acidosis even after we have put them on a stringent diet, and we don't know what the effect will be on youngsters, but I don't believe I would want my patient to go through pregnancy if she were a diabetic.

Dr. A. L. Walters, Miami Beach:

Diabetes in children today is up to the psychologist as well as the doctor. They not only have to treat the child but they have to treat the parents. It becomes very irksome if the child has to take insulin for perhaps months or years. They get tired of it. And it is very hard to control them from stealing food, as the best behaved children will do it unless carefully watched. There is one way in which that can be avoided, and that is to give the child a normal diet. And with the use of insulin there is no reason why a diabetic child should not have a diet approaching normal, a diet which will satisfy the child. It has been found that insulin will burn more sugar the more sugar is fed; that each unit of insulin will then burn three or four times as much glucose as when on a low carbohydrate diet. If the child has to take insulin anyway, why not give it a normal diet and a little larger dose of insulin? There can be only two objections brought forward against this method of treatment. One is perhaps the additional cost, but that can be disposed of easily, because it is cheaper to give more insulin and less fats than to give less insulin and more fats. Fats are the expensive part of our diet. By actual figures you will find that a high carbohydrate diet will be cheaper and offset the increased cost of the number of units of insulin required. Insulin costs only ¾c per unit. So the matter of economy does not enter into this diet. The other objection is the increased danger of large doses of insulin, but strange to say there is very little added danger. For some reason not yet understood, a patient on a high carbohydrate diet can withstand quite a variation in the unitage of insulin without showing symptoms of low blood sugar. So these two objections can be dispensed with.

Another point brought out by Dr. Limbaugh but not stressed particularly, is the danger of infections in children who have diabetes. Every infection tends to lower the patient's tolerance. Another thing that often brings a patient to grief unless the situation is well understood, is the fact that when a child does get an infection he may have fever and have a little less appetite, and the physician may lower the diabetic diet. At the same time, being afraid, he also lowers the insulin administered. That is just the time for that child to very likely go into a state of coma. Even if the diet is lowered insulin should not be lowered proportionately. It may have to be lowered somewhat, but a child with fever requires much greater doses of insulin than one without.

Another point about a high carbohydrate diet I wish to mention is the fact that it has been shown in a certain number of cases that patients who have been well standardized for at least two years on a definite dose of insulin and definite measured diet have at the end of two years changed to a high carbohydrate diet and gained materially in their tolerance.

Dr. S. H. Toy, Umatilla:

I would like to ask Dr. Limbaugh in closing to discuss the use of grapefruit in the treatment of diabetes. I have been told that they are using it in Chicago, and that a great many Chicago people have been greatly benefited by the administration of grapefruit. I would like to have him discuss this.

CONCLUSION.

Dr. Limbaugh, Jacksonville:

I might say, first, that I was endeavoring to brighten the outlook of diabetes in children, and of course, purposely stayed away from all detail

of diet. I enjoyed the discussions, however, very much.

The tendency now is, I think, to give more carbohydrate and not quite so much fat. That may answer the question of arteriosclerotic changes after we have followed these children through and they have reached adult life. We were attempting to look ahead when we brought up the subject of arteriosclerosis in children, and stated that we realized that it did not pertain directly.

As to grapefruit being used in the treatment of diabetes other than as a part of the regular estimated, I am not able to discuss, save to say that personally I think when grapefruit is included in the diet it is simply included as one of the fruits of 5% carbohydrates—some are rated as 10% and some as 5%. I am not familiar with their use in any other way. However, I have heard that discussed somewhat indirectly before.

As to the children getting their insulin: I have not had any difficulty in getting them to take it. For example, I noticed a patient four years of age had occasion once or twice to go to the nurse, and holding his arm up as she was about to feed him, say, "I have not had my stick", and seemed willing to get it.

MERCUROCHROME IN THE TREATMENT OF SEPTICÆMIA OF MASTOID ORIGIN*

T. H. Odeneal, M.D.,
West Palm Beach.

Mercurochrome was first employed in the clinic of Dr. Hugh Young, both locally and intravenously, and has since become one of our most universally used drugs.

Great care should be taken in the preparation and administration of the drug and initial maximal doses are contraindicated except in extreme cases. The reaction of different individuals varies greatly, and while some will not be affected by continued treatment, others will manifest a hypersensibility for it. Young has published an exhaustive paper on mercurochrome therapy which covers a variety of diseases, which should be read by every practitioner. Hill and Bidgood demonstrated that mercurochrome in strengths up to 7.5 mg. per kilogram body weight does not produce changes in the kidneys, but when the dose is increased to 10 mg. per kilogram slight damage will occur which clears up in two months. The kidneys, as explained by Redewell and Potter, carry off small amounts of mercury when in a healthy state and are the main emunctory for this drug, but so soon as damage of the parenchyma takes place (from disease or overdose of the drug) the dye is turned back to be excreted by the intestinal tract. The gastrointestinal and urinary tracts have a definite ratio for the excretion of mercury. This, as shown by Lee, is 55 for the urinary and 45 for the intestinal tracts. Piper has revealed that patients with good resistance and healthy kidneys withstand larger doses and improve more rapidly than those with slightly damaged kidneys and low resistance, and cautions against the administration of larger doses in the presence of lowered resistance.

The best results are obtained by small doses at first, gradually increasing the dose, so as not to get a too early saturation of the system with the drug. The most favorable cases are those which give mild reactions.

The bacteriostatic action of mercurochrome is strongest in the blood during the first hour and in the urine during the first five hours. Piper, who is one of the pioneers in this field, states: In patients that are not in extremis but with positive blood cultures we proceed in the following manner: An initial dose of from 20 to 30 c.c. of a 1% solution of mercurochrome is given, depending upon the weight of the patient. This dose is not intended to be in any way curative, but is given primarily to observe the action of the kidneys. If following this first dose there is no apparent decrease in the excretory function of the kidneys, nor increase in the evidence of acute nephritis, we proceed to use what we now consider the maximum dose. This is estimated as 30 c.c. for the first one hundred pounds of body weight, 5 c.c. additional for each thirty pounds above the first one hundred, with a maximum dose of 45 c.c. for any one beyond the two-hundred-pound mark. This is merely a working rule and I should have no hesitancy in exceeding this dosage under certain conditions. Piper further states in a recent number of the Journal of the American Medical Association, two cases of ptyalism are reported following the intravenous use of mercurochrome. I would call attention to the fact that the danger of this condition was

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

mentioned in my original paper. It was suggested to me recently by one discussing this method of treatment that the reaction that occurred was due to mercury poisoning. We had always surmised this to be the case, at least to a great degree, but we felt there was a basis for our hypothesis that some of the chill and rise in temperature might be due to the destruction of micro-organisms within the blood stream. This is being borne out in a considerable number of cases. Our results have varied with the different types of micro-organisms shown to be present. They have been good for the staphylococcus and for the streptococcus hemolyticus and non-hemolyticus. This drug in my hands has been utterly useless in the streptococcus viridans. Experimentally it has been of slight value in the pneumococcus. In closing Piper states: 1. This treatment is not infallible. 2. Early diagnosis must be made. 3. Lives have been saved by this method which would otherwise have been lost. 4. We do not believe that this method of treatment is by any means the last word in these conditions, but we do believe it is a step in the right direction. 5. We cannot too strongly impress upon the profession that in spite of reports of brilliant recoveries this is undoubtedly a dangerous procedure and is only warranted by the severity of the condition with which we are confronted. Its promiscuous use is to be discouraged, as this will unquestionably bring whatever merit the treatment may possess in definite disrepute.

Cases cured by intravenous therapy with mercurochrome are too numerous to report here. Some of the more interesting are the following: Trout and Groseclose report a positive diplococcus septicæmia following tonsilitis with thrombosis of the jugular vein with recovery. Schwab reports recovery from streptococcus septicæmia complicating mastoid infection. Porter reports three cures of septicæmia complicating mastoiditis, one a pneumococcal infection, but this case had also had the jugular vein tied, so it was impossible to determine the value of the mercurochrome. In the Young and Hill series of cases reported the colon bacillus and staphylococcus predominated. Harris reports a case of furuncle of the nose with complicating septicæmia. With the exception of the cases reported by Schwab and Porter I can find no other evidence of mercurochrome having been employed for septicæmia of otitic origin. This condition is met with frequently and since all cases of septicæmia are serious, it is my opinion this method of procedure should be given a trial, but not at the expense of ligation of the jugular and other operative procedures that may be indicated. It may be advisable to make use of one of the other dyes in place of mercurochrome where the first injection is without effect. We know that gentian violet will destroy all gram positive germs and we know that acriflavin will destroy all gram negative germs, and acriviolet both gram negative and gram positive organisms, therefore it is believed that further experiments in the intravenous use of dyes will be of inestimable benefit to mankind.

There can be no question that mercurochrome is most effective against the staphylococcus and colon bacillus, so much so that it can almost be classed as a specific against these organisms.

Technic Employed—The solution should be freshly prepared and given every forty-eight hours or according to the result obtained. A 1% solution of mercurochrome, made by dissolving ordinary mercurochrome 220 soluble tablets in hot distilled water (it is not necessary to sterilize the solution), is allowed to cool and injected slowly in a large vein in the bend of the elbow. At least 3 mg. of the mercurochrome should be employed to each kilogram of body weight. This amounts to in the neighborhood of 23 c.c. of a 1% solution of mercurochrome to each one hundred pounds of a patient's body weight. In severe cases as high as 8 mg. per kilogram body weight may be given, but according to Young, never more than this.

Case—The patient was a boy of twelve, who had from time to time acute exacerbations of a chronic otitis media, with intermittent dry and wet periods. I was called to see the child to find he had a temperature of 104, which did not lessen the next day. Both ears were discharging. The family physician pronounced the lungs, kidneys, etc., normal and he was carried to the hospital on the second day after I had seen him. An X-ray disclosed both mastoids very cloudy but of a sclerotic nature, which was to be expected in a long-standing case. On operation, a bilateral modified radical exposure, the mastoids were found to be ebonized, with very few cells and the sinus plates on both sides ivory white, which indicated the lateral sinuses were normal. After operation the temperature continued elevated, running as high as 105.5, the patient becoming comatose. A remarkable feature of this case was that the pulse never went over a hundred, and

as is often the case, no chills were present. A blood culture proving negative for septicæmia, the blood was tested for typhoid as this will often resemble septicæmia; malaria was also ruled out, as was tuberculosis. A second culture taken later gave a pure strain of staphylococcus aureus.

Now that it was definitely established that a septicæmia was present and no other focus of infection having been discovered, there must of necessity be an infection, by way of the ear or mastoid, of one of the sinuses of the brain, and most probable, one of the lateral sinuses, but which side was affected could not be discovered without an exploratory operation, and this I did not think advisable, due to the intact sinal plates. Dr. George Tobey's interesting discovery, by means of the positive Queckenstedt test, of detecting the presence of thrombosis of the sinus and the side involved, had not been published and I therefore did not have this to aid me. Finally it was deemed advisable to resort to mercurochrome and not employ any further operative procedure.

A first injection of 3 c.c. of a 1% solution of mercurochrome was given intravenously which caused a severe reaction but brought the temperature down on the second day to 100 F., which was the first time it had been below 104 F., when a second injection of 5 c.c. was given, without a reaction, and this was followed by an injection of 7 c.c. with some reaction. The blood was still positive, but after another injection of 7 c.c. gave a negative reaction and the patient was to all appearances entirely recovered, and has remained well since, after a two-year period. At no time was there albumen in the urine or any intestinal derangement.

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DISCUSSION

Dr. H. Marshall Taylor, Jacksonville:

I am glad Doctor Odeneal brought this subject before us. The only way we are going to come to a definite conclusion relative to the mercurochrome treatment of sinus thrombosis of otitic origin is by a large number of case reports which are carefully worked out and only from a large number of cases can our deductions be of value.

Recently I have had occasion to use mercurochrome in a case of sinus thrombosis which showed a streptococcemia. An internal jugular ligation was done without any evidence of improvement; the patient continuing to have chills daily, with a temperature reaching 106. 18 c.c. of a one per cent solution of mercurochrome was given. A definite improvement in this case was immediately shown, cessation of chills, a decrease in leucocytosis, and patient ultimately recovered.

The recent literature on this subject leads the otologist to believe that mercurochrome will play a valuable role in the treatment of sinus thrombosis.

CONCLUSION.

Dr. T. H. Odeneal, West Palm Beach:

I think that at the time mercurochrome first came out we all knew there was a great deal of experimenting going on. But at the present time it is on a pretty firm foundation just what mercurochrome will do in the majority of cases.

I think it should be held just for the serious cases alone, and not employed for every type of case. Now, septicæmia of course is a very serious condition, and my own personal opinion is that mercurochrome should be used in every case of septicæmia and given a trial, but just as I said

in my paper, not at the expense of surgical procedures. I believe in surgical procedure before all else—first surgical procedure and then mercurochrome, I think that is about the basis now.

SQUINT*

Shaler Richardson, M.D., F.A.C.S.,
Jacksonville.

Strabismus, squint or cross-eye, may be said to exist when there is inability to fix an object with the two eyes simultaneously. An object is said to be fixed when the eye is in such position that an imaginary line may be drawn from the object passing through the optical center of the eyes to the macula. This imaginary line is termed the visual axis. The normal ocular apparatus, when looking at an object, fixes it with both eyes, or in other words, the visual axes converge simultaneously upon the same object. With both eyes open, if in looking at an object, one eye fixes it while the other turns inward, the condition is known as convergent squint. Should one eye turn outward, it is termed divergent squint. Occasionally one sees an upward or downward deviation of the non-fixing eye, but the lateral deviations are by far the commoner.

With the visual ray passing to the macula of each eye, a visual impression is made on each retina. These impressions are in turn transmitted backward along the optic pathways to the visual centers. The two images transmitted to the brain are fused and in this manner binocular vision is obtained. Experimental demonstrations of the fusion faculty may be made by looking into the ordinary stereoscope. Two similar objects are viewed by separate eyes and instantaneously fused or blended by our socalled fusion centers.

It is interesting to note that even in earliest infancy the fixation reflex is present. For example, if a light is thrown into the eyes of an infant just a few days old, the eyes will immediately turn toward it. The fixation is held only momentarily. After several months the infant will show a desire for binocular vision and this desire increases progressively with the development of the child.

According to Worth, the fusion faculty is complete by the end of the sixth year, and if not developed prior to this time, the faculty is irreparably lost. When an eye deviates, it is obvious that the image transmitted by it to the brain must be suppressed in order to avoid double vision. Once this has occurred, it is difficult or impossible to reestablish vision in this eye.

In order that one may understand the more important contributing factors in squint, it will be necessary to briefly refresh your memory as to the commoner refractive states.

(1) Emmetropia—the normal eye or one in which parallel rays are focused on the retina when the muscle of accommodation is at rest.

(2) Hypermetropia—the short or far-sighted eye or one in which parallel rays are focussed behind the retina. The muscle of accommodation may or may not be able to overcome this.

(3) Myopia—the long or near-sighted eye or one in which parallel rays are focused in front of the retina. Even though the muscle of accommodation is in a state of extreme relaxation, the parallel rays cannot be focused on the retina.

(4) Astigmatism—a variance in the arc of the refractive meridians. This is the commonest refractive error and may be combined with either myopia or hypermetropia.

Accommodation: It is obvious that if in a normal eye parallel rays of light are focused on the retina, that in looking at a near object divergent rays enter the eye. Some additional refractive means is necessary and this is afforded by the ciliary or accommodative muscle, which by contracting causes an increase in the convexity of the crystalline lense and thus brings the divergent rays to a focus on the retina. Convergence: In looking at a distant object we generally consider the eyes as being parallel. In looking at a near object, the visual axes must converge, or in other words the internal recti muscles must contract. Accommodation and convergence are synchronous, for in viewing near objects we must have both faculties, if we are to accomplish acute vision. These functions are most important in considering the etiology of squint, for the majority of convergent squints are associated with a hypermetropia, which necessitates more than the normal amount of accommodation in order that an object looked at may be focused on the retina. This in turn causes an over-amount of convergence and the internal squint is the result.

*Read before the Alachua County Medical Society, April, 1926.

A brief classification of the etiology of squint will be appropos at this time.

1. Refractive errors—(a) myopia, (b) hypermetropia, (c) astigmatism, (d) anisometropia (unequal refractive errors of the two eyes).

2. Defects in the fusional faculty.

3. Anatomical defects as paralysis of ocular muscles and congenital anomalies.

4. Blindness.

Squints resulting from ocular muscle paralysis are of especial interest to the general practitioner. The deviation may be outward, inward or vertical, depending upon the particular muscle or muscles involved. A squint due to paralysis may be differentiated from other types of squint by determining the inability of the patient to turn the eye in the field of action of the muscle involved. Syphilis is the most frequent cause of ocular muscle paralysis. Diphtheria, whooping cough, epidemic meningitis, influenza and the acute exanthematous diseases are also frequent etiologic factors. Congenital anomalies are occasionally a factor. The treatment of this type of squint is the treatment of the general condition augmented by some of the usual methods of treating the ordinary squint.

The general physician is the one who usually has first contact with patients afflicted with the squint deformity and for this reason it is paramount that he should inform himself as to the hazards that will result in untreated cases. Too often the fond parents of a cross-eyed child are told that their child will outgrow the deformity and procrastination results in a continuance of the cosmetic handicap, as well as permitting a rapid deterioration of the vision in the deviating eye. Many of these patients if seen early by a competent oculist could be treated by refractive correction and exercises and the necessity of an operation avoided. The reasons for advocating early correction of squint are three in number, viz: (1) Loss of vision in the deviating eye will certainly follow disuse and a squinting eye is not used. The rapidity of deterioration may be said to be greater in the very young and that it lessens with the increase in years. (2) Unless treated, loss of binocular vision, or the power to use the two eyes together, will ensue. (3) Cosmetic improvement. Many children grow to adulthood laboring under the severe handicap of being cross-eyed. In school they are backward and timid because of their deformity. They avoid contact with other children. As they mature they become more and more conscious of their handicap and after reaching adult life continue to be retiring and backward. What is more pitiable than a young, otherwise attractive woman with an eye that turns in or out? It is interesting to note the change that takes place in adults who have squint deformities corrected. Frequently a person of retiring disposition and with little care of personal appearance will undergo a complete transformation.

The treatment of squint varies, but every patient afflicted with such a deformity should receive a most thorough examination by a competent oculist at the earliest possible opportunity. The first point to be determined is the cause of the deviation. If a paralysis of an ocular muscle is the etiologic factor, then additional information is to be sought as to the cause of the paralysis. This should be handled in conjunction with the general practitioner as well as the subsequent general treatment that may be necessary. Refractive errors are always to be held uppermost in one's mind when investigating a squint and should invariably be estimated only after a complete relaxation of the ciliary muscle by means of thorough atropinization. It is my rule to have all squinting patients who have a refractive error of any consequence wear lenses continuously over a period of at least six months before advising further steps. Combined with the wearing of lenses, exercise of the lazy or deviating eye is obtained by covering the strong eye for a definite period each day. This forces the deviating eye to fix and in many cases increases vision.

Many patients will require operative interference. The age at which this should be done is a most important point. Frequently parents are instructed to wait until their child reaches the twelfth or fifteenth year of life for the operation. During this time a total or partial loss of vision in the affected eye occurs, to say nothing of the loss of the fusional faculty. As soon as I have assured myself that non-operative measures will not suffice to correct a strabismus I advise operation without delay.

We have in general two operative procedures: 1. The weakening of an overacting muscle; 2. The strengthening of an underacting muscle. The tendon of the muscle at its insertion into the eye ball is severed either partially or completely to effect this weakening in the usual tenotomy operation. The preferable method of increasing the action of a weakenend muscle is by resecting the desired amount and then reattaching the cut end to the insertion by suture methods. Fre-

quently it is necessary to combine the resection and tenotomy in order that the desired result may be obtained. Local anesthesia, namely cocaine, is effective in all adults and many children, although at times general anesthesia is necessary.

In concluding let me stress the following points:

1. Squint demands early correction to save the vision of the affected eye, to preserve fusional faculty, and to remove a most serious handicap to the patient's physical appearance and progress in life.

2. After once determining that non-operative treatment will not relieve the squint, operative interference should be undertaken without delay.

3. A large percentage of squints can be overcome by non-operative measures. Those cases that are not relieved in this manner can in most instances be relieved by surgery.

FRACTURES OF THE SHAFT OF THE FEMUR TREATED BY TRACTION*

F. L. Fort, M.D.,
Jacksonville.

Our present age is one of machinery and fast locomotion. There is an ever-increasing percentage of fractures of all kinds. Fracture of the thigh is a common injury. Also, it is a major injury, which gives us much concern. For in spite of the wonderful advancement in recent surgery, the only person who has *no* bad results in fractures of the femur is the man who does not treat them. A perfect result is still cause for congratulation, while a poor result is a life-long testimonial of the surgeon's inefficiency.

Time forbids a consideration of the treatment of all fractures of the femur. Consequently we will only discuss fresh fractures of the femoral shaft not involving the head, neck, trochanters or condyles of the femur. The types of fracture are, simple and compound, tranverse, spiral and comminuted.

The method of treatment I wish to present to you is not new, altho it has been popularized or practiced more generally since the World War. I refer to the use of traction and counter-traction on the point of fracture, by any one of the several means available. The use of traction, when intelligently used, has repeatedly proven to be the safest, most efficient, and possibly the quickest method of treating a fractured femur. The percentage of bad or poor results treated by efficient traction will be much lower than by any other one method.

Occasionally open operation must be resorted to in severely comminuted fractures with badly displaced fragments, or in the long spiral fractures with soft tissue intervention. Compound fractures usually require open operation for removal of foreign bodies, devitalized tissue, and replacement of the fracture. The subsequent treatment of compound fractures following debridement operations, should always be that of constant traction and counter-traction the same as for closed fractures.

Complete fracture of the shaft of the femur always develops one or more of the deformities of rotation, angulation, or overlapping of the fragments. These deformities result from the force of gravity and from muscle pull (or spasm). Both are always present. The aim of all treatment is to overcome these two forces, and maintain the corrected position until union occurs. The best method of obtaining this result is what concerns us today.

The common method of applying a plaster cast from the waist down to the ankle after reduction has three principal objections:

First, rotation is not prevented unless the foot is included in the cast.

Second, it is next to impossible to overcome the tendancy towards overlapping or slipping of the fragments later, even though strong traction is made on the leg while the cast is being applied.

Third, a cast applied about the thigh tight enough to prevent motion at the site of fracture interferes greatly with the circulation of the limb, and results in delayed callous formation and muscle atrophy. A cast that is applied tight will be quite loose within ten days to two weeks, due to decrease in swelling and muscle atrophy.

Having already admitted that a few fractures of the femur require open operation, I wish to stress some of the dangers or contra-indications of this method, when used routinely.

Foremost of these dangers is that of infection. The extra trauma of open operation added to that of the original injury lowers the local resistance of the tissues against infection to a dangerous degree. Foreign bodies of all kinds are always irritating to the tissues and predisposed to infection. With the most painstaking technique and the best of hospital facilities, infections will occur in too many cases, where screws,

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plates, wires, bands, etc., are used, to make their use a routine procedure. I do not believe they should ever be used primarily in compound fractures. We often see well reduced fractures, later with the wires or plates broken, or screws pulled out and the deformity recurring.

Another objection to open operation is that of adhesions of the muscles to themselves, to the skin, or the bone. This results in limited knee flexion and pain on motion for an indefinite period of time.

Fracture of the femur is always accompanied by considerable shock, especially in the old or debilitated. The extra shock of open operation is sometimes more than we are warranted in inflicting.

Sometimes the patient with a fractured thigh presents some visceral lesion, particularly of the heart, lungs, or kidneys, which contra-indicates, or even excludes any operative procedure under anesthesia.

Maintaining fixation is practically as difficult following internal fixation operations as in those cases treated otherwise. Likewise the daily inspection of the leg for measuring, or for physiotherapy is impossible when casts are used. A final objection is that people do not like to be operated upon whenever it is avoidable. Personally I would consent to operation only as a last resort. The patient, when allowed to choose, will always prefer the conservative or non-operative method of treatment, if equally effective.

There are several distinct advantages in the traction method of treating fractures of the thigh routinely:

First, hospitalization of the patient, altho preferable, is not essential. Efficient treatment can be carried out in the home when adequate hospital facilities are not available.

Second, there is no danger of infection from treatment by the traction method.

The correction of the deformities of angulation, overlapping or rotation is fairly easy in the vast majority of cases, where sufficient *pull* is exerted. Occasionally in very muscular subjects, extension up to 40 or 50 pounds is necessary to overcome overlapping of the fragments. With sufficient extension, every fresh fracture can be corrected. Traction overcomes muscle spasm and consequently removes the most potent force in producing deformity.

The soft tissues, when put under tension, are pulled out straight and from between the ends of the fragments. Non-union from soft tissue interposition will practically never occur in the traction method of treatment. Also badly comminuted fractures are often better reduced by putting the thigh muscles under tension, than by any other procedure.

The difficulty of maintaining position after reduction, by whatever means, is our great problem. With sufficient traction however and the leg in a ring splint, the task becomes quite simple. However, daily inspection and the use of the tape measure must be done religiously for the first two weeks or more. Any tendency towards deformity is readily detected and also easily corrected.

The patient's comfort, in my experience, has been greatly augmented by the traction method of treatment. Large plaster casts are ill-borne in most cases, especially in our semitropical climate. Fixation with sand bags or boards is not effective or comfortable.

The time of solid union and mobilization of the leg is shorter in most cases by the traction method than by any other. The circulation of the leg has not been impeded. The muscles are not so badly atrophied, especially where massage and baking have been used. Callous formation with good circulation is more rapid than when the leg is encased in plaster.

The ideal treatment of fractures is to get solid union in the shortest period of time with the least amount of pain and deformity. I am firmly convinced that this goal is nearer obtained by some form of traction and counter-traction, in fractures of the femur, than by any other method.

As to the best method of applying this form of treatment, no fixed rule can be given. Each case must be treated according to circumstances. Children under seven years of age are most conveniently treated by overhead traction with adhesive tape on the leg from the point of fracture down to the ankle. The body weight acts constantly as the counter-traction. The bedside care of the patient is easy; while results are excellent.

The majority of the cases are most conveniently treated by means of adhesive skin traction applied from the point of fracture down to the ankle and ending in tapes which are fastened to a foot rest. From the foot rest a rope is extended over a pulley at the foot of the bed. The necessary weights are attached to this rope. The extended leg lies in a ring splint simply as a trough for protection. Canvas slings can be

used about the thigh to overcome any tendency towards bowing in any direction. Rotation is prevented by binding the leg in the splint. Then the leg and splint can be maintained as one, in any desired degree of rotation or abduction. The leg and splint are elevated about 30° while the foot of the bed is elevated a like amount, so that the body weight acts as a counter-pull. If it is desired not to lower the head of the bed, the patient can be fastened to a Bradford frame, so as to fix the upper fragment. The frame facilitates the nursing care, especially in heavy adults.

I have found counter-traction by pressure of the padded ring up against the ischial tuberosities not satisfactory. Because it is uncomfortable to the patient, and often causes pressure sores. It is difficult to maintain sufficient traction in this manner. Likewise fastening the foot to the bed or end of the splint is not satisfactory, because every move made by the patient disturbs the fracture. Extension should be by means of weights and pulleys, which gives a constant traction whether the patient moves up or down in bed.

In muscular individuals adhesive skin traction is not sufficient to overcome muscle spasms and overlapping of fragments. In these cases it is necessary to use skeletal traction, preferably by means of calipers or ice tongs fastened to the femoral condyles. This method will always enable you to secure sufficient pull to correct and maintain position. By this method the knee can be mobilized from the outset, which cannot be done by any other method. Contrary to appearances or popular belief, there is very little pain caused by the calipers. They can be applied under local anesthesia. The danger of infection is negligible. Rotation is easily controlled.

In conclusion I wish to repeat that the nearest approach to ideal treatment of fractures of the femoral shaft is and will be by one of the several methods of traction and counter-traction.

DISCUSSION

Dr. R. A. Ely, Tampa:

I don't think we can disagree with Dr. Fort on anything; I think his paper was well gotten up.

But there is one thing I would like to reenforce. There seems to be a difference in opinion, as always in the practice of medicine, concerning the use of plaster paris. During the last year I bought, I think, the latest text-book on fractures, and about the same time Robert Jones came out with a statement which entirely disagrees with this book. This text-book says put up all fractures in plaster; and over this text-book Robert Jones comes out about the same time and says that it is a pernicious practice to put all fractures in plaster. Now, I think that Robert Jones is more nearly correct than the other man. I think that when we have a fracture the very best thing is to first treat it in extension like this, or put it in some kind of splint, and then later on if you want to, put on your plaster—that is in certain other fractures, but in this particular fracture I don't think that there is anything else but extension. I have seen not a few cases where plaster was put on and the edema afterwards was terrible. And for that reason I think that one point should be stressed—plaster should not be put on any fracture at the beginning.

Dr. J. K. Simpson, Jacksonville:

Unfortunately, I did not hear all of Dr. Fort's paper. I know Dr. Fort's work, though; have seen a good deal of his work, and his X-rays do not do his work justice. They never do any man's work justice who is doing competent fracture work. Because X-rays do not show the result that we are aspiring to. They show that a bone is in line, but they do not show that you have well functioning joints above and below the fracture, that you have competent well functioning muscles, and an absence of this hard brawny edema that frequently occurs in poorly treated fractures. I think the X-ray has made us hypercritical of our anatomical results, but after all anatomical results are not so important, I think, as the physiological results. That is, get a well functioning extremity by treating these cases, no matter what method you might use. My personal preference is for extension and mobilization of the joint above and below at the very earliest possible moment. My method in the way of fractures has changed very largely since I first started out. I had the idea that the main thing was to get the bone in position and hold it there regardless of whatever else might happen. And now, especially in Colles fractures, we put a splint on for a week and after that practically no splint at all, or possibly a little bit of board two or three inches long with adhesive strip along the wrist. Fractures properly reduced will stay reduced without any extraordinary efforts or any extraordinary mechanical appliances. The main idea is to get the fracture in the proper position

and then pay most attention to muscles and joints.

I know Dr. Fort does this. I have seen his results and know they are excellent, and the last X-ray of course is a peach. But I don't think that X-rays ever do justice to a man's work when he has worked out competent fracture work.

Dr. F. J. Waas, Jacksonville:

I am very anxious to have Dr. Teeter put in the slides of the case that came under my observation that Dr. Fort so excellently handled. There are a few points I would like to bring out that made a very wonderful impression on my mind.

This case was operated by my associate, Dr. W. R. Schnauss, as I was out of the city at the time. The thing I would have done was exactly what Dr. Schnauss did—put in a bone plate. After reduction under anesthesia, he could not get any position at all, so he decided to operate and put in a bone plate. As you see, the alignment is very nearly perfect in every way (demonstrating with slides). But, unfortunately, we got no union even though everything was absolutely perfect. She developed evidence of infection, so I went in myself and took the plate out. The mistake that I made was in not putting traction on after removal of the plate. I felt that the plaster would hold in position, but the patient was a non-cooperative patient, very hard to control, and that, I think, is what caused the bad results that we had. At the time that Dr. Fort was called in on the case, we were thinking of doing a sliding bone graft, which, to my mind, was the way I would have handled this case. But the case was turned over to Dr. Fort, and this (demonstrating) just shows what traction will do.

When we went in and took the plate out, we got some displacement. I believe that if we had put traction on we would probably have been able to get the same result that Dr. Fort had. I want to commend Dr. Fort, because this is one case that I watched almost through, and I must say the results are wonderful from a traction standpoint.

CONCLUSION.

Dr. F. L. Fort, Jacksonville:

As to the plaster cast, I don't think you can lay down any definite rule.

Never use a plaster cast in the beginning as there is too much swelling. There are other methods by which you can immobilize fractures. However, it is a matter of what is the most convenient means of immobilizing the fracture in reduced position, and sometimes the cast is indispensable. That is, I think sometimes we are almost obliged to use them, but just to use them absolutely as a routine is not necessary, and is in my experience a very poor policy. Dr. Simpson, I think, is quite right in saying that the X-ray does not do justice to the end result in fracture work. What is anatomically, as seen in the X-ray, a very poor result, may be an excellent physiological or functional result; and that after all is what we are striving for. And as I stated in the paper, if by this traction method you can get them back on their feet without deformity you can then apply physio-therapy—which you cannot do in a plaster cast.

I wish to thank Dr. Waas for explaining his case, also.

LEAD POISONING IN CHILDREN*

L. W. Holloway, M.D.,
Jacksonville.

Every physician is familiar with the type of child who has a perverted or capricious appetite for articles which are not natural foods.

This condition is known as pica or parorexia.

Ruddock[1] in a very illuminating article has called attention to the hazard of lead poisoning to children who suffer from pica.

These children gnaw and eat any article with which they come in contact.

All painted objects such as certain toys, white furniture, rails of kiddie-coops, porch railings, window sills and powder cans may afford the means by which little children become the subjects of chronic lead poisoning.

Lead gains entrance to the organism through the gastro-intestinal tract. This has been thought to be the main avenue of introduction.

Holt,[2] in 1923, reported a case of lead poisoning due to the inhalation of dust containing lead.

Aub,[3] Minot, Fairhall and Reznikoff, in a report of studies, made in the laboratory of physiology at Harvard University, on the absorption and excretion of lead, state "that lead given to cats by stomach tube is soon recovered in large amounts from the feces. Later it became clear that this occurs partly because most of the in-

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gested lead is not absorbed, and partly because a greater portion of the fraction that is absorbed is caught by the liver and reexcreted into the intestinal tract in the bile.

"Absorption from the respiratory tract on the other hand is very rapid and dangerous. Blumgartt, working in this laboratory, found that, within twenty-four hours, a relatively large amount of lead could be absorbed by the organism when the only path of entry was through the nose and mouth. This he did by tying off the esophagus in cats, and by inserting a canula into the trachea, through which the animal breathed. In such a preparation there is no connection between the naso-pharynx and the lungs or the stomach, and inhaled substances cannot enter the gastro-intestinal tract. Lead carbonate dust, even though it is quite insoluble, is rapidly absorbed when sprayed into the nose under these conditions. Blumgartt determined this by analyzing the various organs of the body for lead.

"Injection of lead into the trachea and so into the lungs of the animals prepared in this way leads to similar results. Indeed as much lead may be absorbed from one injection into the respiratory tract in one day as from the gastro-intestinal exposure lasting for months. The degree of respiratory absorption is evidenced not only by the quantity of lead absorbed, but also by the rapid appearance of the lead line and other characteristic symptoms."

I will report here data from eight cases of lead poisoning which have been observed by me.

Five patients were boys, three were girls.

The ages ranged from eleven months to four years.

All gave histories of being subjects of pica.

Every case presented a clinical picture of secondary anemia. The hemoglobin averaged fifty-five per cent. There was a reduction in the total red count ranging from one-half to one million cells. Three of the cases showed stippling of the red blood cells. One case showed eighteen to twenty stipple cells to each field.

All the patients were constipated and two had periodic attacks of diarrhœa.

Colic was a prominent feature in each of these cases.

Five had vomited off and on since exposure to lead had begun. The exposure to painted objects ranged from four months to sixteen months.

The lead line was observed in only one case and that in one who had inhaled lead dust.

No paralyses were observed.

Lead was recovered from the stools in five cases.

Lead was found in the urine in three cases.

Two cases of the series represent types of acute poisoning from inhalation of lead superimposed on the chronic intoxication. These two cases showed the picture of lead encephalopathy or involvement of the nervous system.

The first case of this type had slept for two nights in a room freshly painted. This occurred during January. There was very little ventilation and consequently the child inhaled a lead-laden atmosphere. He became violently nauseated and had severe cramps in the abdomen revealed by his sharp cries. Vomiting ensued and persisted for eight to ten hours. This was followed by generalized convulsions which lasted for fourteen to sixteen hours.

The second case inhaled lead dust while in a room where paint was being scraped and sandpapered from lumber which had been previously used. This child had generalized convulsions for thirty-six hours and in the intervals between seizures would remain in a state of coma. Double choked discs were present in this case.

Lumbar puncture was done on these cases and the fluid was under great pressure. The puncture relieved the convulsions.

The history of exposure to lead helps to differentiate this condition from brain tumor, encephalitis, cerebral hemorrhage and tuberculous meningitis. The finding of lead in the urine and feces and the presence of stipple red blood cells clinch the diagnosis. The spinal fluid of the last case was injected into a guinea pig to differentiate this case from tuberculous meningitis. The guinea pig lived.

TREATMENT

There are three phases to the treatment.

1. The most important is prophylaxis by informing parents of the hazard of painted articles to little children. Varnishing all articles with which they come in contact will prevent poisoning.

2. For the convulsions lumbar puncture has relieved the situation in our cases. For the anemia tonics and fresh air are indicated.

3. Melser in 1840 first used potassium iodide to promote the elimination of lead from the organism. This is now believed to be dangerous

in some cases by causing an aggravation of symptoms as the lead deposits are released from the hard portions of the skeleton. Aub et al. recommend the use of ammonium chloride in a dose of eight to twelve grams a day or twenty to twenty-three c.c. of dilute phosphoric acid sweetened like lemonade as the best eliminant of lead, they also recommend the use of sodium bicarbonate in a dose of forty grams in twenty-four hours to hasten the elimination of lead. They state that twice as much lead is eliminated with the use of the acid as when the alkali is used. A diet with a low calcium content furthers the release of the deposited lead. Milk is contraindicated owing to its high calcium content. A diet such as meat, potatoes, rice, macaroni, apples, bananas, sugar, salt and milk-free bread is recommended for these cases. Milk and eggs and other articles not included in this list should not be considered in the dietary.

CONCLUSIONS.

1. Lead is a hazard to small children.
2. Many cases of lead poisoning are overlooked.
3. Education of parents through public health agencies as to the likelihood of lead poisoning in children is suggested.

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TEST FOR LEAD.

Considerable urine is evaporated to dryness, and 50 c.c. of fuming nitric acid is added; after the reaction has subsided, it is allowed to simmer over the free flame for one-half hour, and then 25 c.c. more acid is added three times each fifteen minutes. The fluid is then evaporated to a small volume, neutralized with sodium hydroxide, filtered and the lead tested with hydrogen sulphid, which will give a brown precipitate.

DISCUSSION

Dr. W. W. Kirk, Jacksonville:

I think that Dr. Holloway is to be commended for bringing to the attention, as Dr. Osincup remarked, of the profession to this condition of lead poisoning in children.

In the larger industrial centers it is a very common thing to find lead poisoning in adults—so common that all the hygienic procedures taken against it are apparently so well known to the laborers in the plant that often very little real attention is paid to it by them.

I think that lead poisoning in children is a condition that is sporadic everywhere, because the supply is ever present. Lead in very small quantities can give trouble to susceptible individuals.

Regarding the laboratory end of this lead poisoning proposition: As you probably know, the man who is associated with the laboratory and is given a number of different specimens to give some definite and reliable answer on to the awaiting surgeon or internist is called on sometimes to do a great deal. And we are called on to give very definite answers as a rule. I feel if the condition, lead poisoning, is suspected, that this is one of the conditions in which the pathologist can render real service, because the test for lead is not difficult. It is present both in the feces and the urine. The blood picture, although not absolutely distinctive, is quite characteristic.

There is a good deal of talk about stippling of the red cells in lead poisoning. Stippling of the red cells is found in practically any severe blood disturbance, particularly in severe pernicious anemia cases and at times in leukemic conditions. It is one of the commonest things that is found in lead poisoning. The red cells easily become stippled and we quite often find fifteen or twenty points to each cell. The red cell count is not particularly helpful as you hardly ever have less than four million, hemoglobin from 50 to 70 per cent. In our malaria districts in Florida, where the resistance is quite low, I think we often find routinely hemoglobins of 50 to 70 per cent.

The point of coming to a final diagnosis: This would rest more upon the demonstration of lead oxide in the urine and feces. The lead salt is also found in the bony substance. Sometimes the lead deposit is distinct; however, the lead is only eliminated from the bone when it is a great deal in excess and natural hardening of the salt takes a long time for elimination.

It is not necessary to go into technical detail as to localizing and detecting of the lead salt. That is a very technical thing. I want to emphasize one thing: If you are just going to test the urine or feces once, you will probably get a negative report in these cases. It is more or less like a tubercular condition in this regard.

(*Continued on page 100*)

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HARVEST MITES OR RED BUGS

A rather common pest, which has a wide distribution and is most prevalent during the summer and fall months, is the harvest mite, also called red bug, chigger, or jigger. It is so small as barely to be seen by the naked eye when penetrating the skin close to the root of a hair, attention having been drawn to the spot by slight burning or itching. Later on, the intense itching that is set up by these semi-parasites interferes with sleep, and by scratching to relieve this itching, a severe skin infection and inflammation may be produced particularly in children. As the mite penetrates deeper into the skin the itching increases, a slightly reddened area makes its appearance at the root of the hair, and increases in size, usually reaching its full development about the third day, when it is perhaps a half inch in its greatest diameter, sharply defined and very irregular in shape. In another day or two the itching subsides and the red spot gradually fades.

Harvest mites are collected on the clothing and shoes by brushing against the trees, shrubbery, stumps, logs and decaying leaves and twigs in the woods—then they start crawling and when they come to a fold of skin or a point where the clothing is tight, they start to burrow. They are likely to be most numerous at the shoe top, under the garters or belt line, in the groin, between the thighs, and around the armpits. Sulphur, sifted into the clothing before going into the woods, is a good repellent. A thorough bath, first with kerosene, then soap and water, and a complete change of clothing after such a trip will often prevent much annoyance. The clothing must not be worn again for several days unless laundered, pressed or otherwise treated to destroy any remaining mites.

After the mite enters the hair follicle, some relief may be had by dabbing on the affected spot a little butter or salty grease.

WHERE IS FLORIDA'S BLIND BABY?

The International Sunshine Society's Summer School for Blind Babies and very young blind children has just closed. This Institution is located in Summit, N. J., maintained by a philanthropic newspaper club with headquarters at 96 Fifth Ave., New York City, Mrs. John Alden, Founder and President General.

This is the only institution of its kind in this country, one that will take any blind baby from any State of any creed and color and give it exceptional care until it is old enough to take advantage of the State Schools provided for these children.

When Mrs. Alden realized that few of the children blinded at birth or soon afterwards, reached the kindergarten age mentally and physically equipped, she induced her Federated Club, The International Sunshine Society, to establish such an institution to accommodate the care and instruction of any blind baby that sought its protection.

"We have," said Mrs. Alden, "cared for over 600 children since we started this educational work, and 27 States have taken advantage of our efforts, but Florida has sent no babies here; maybe the Florida mothers of the blind don't know about this institution. It is absolutely impossible for a mother to bring up her blind baby alone, and keep its mind normal and its body perfectly healthy. The baby needs exceptional care, day and night, which can be accomplished only by a relay of workers. A mother can not do this alone no more than she can give it a college education alone."

Mrs. Alden urges the club women of Florida to report to her all blind babies in Florida. A proper census might result in legislative action in behalf of these most helpless of all human beings—BLIND BABIES.

STATE NEWS ITEMS

Dr. A. M. C. Jobson of Tampa recently visited many points of interest in Canada and while there spent most of his time doing post-graduate work in some of the large Canadian hospitals.

Dr. C. B. McKinnon of DeFuniak Springs is in very bad health. Every member of the Association extends sympathy to Dr. McKinnon and especially the members of the Walton-Okaloosa County Medical Society. It is hoped that Dr. McKinnon will experience a complete recovery.

Dr. W. M. Rowlette of Tampa recently visited New York where he spent some time visiting clinics, going from there to various points in the Adirondack mountains.

PINELLAS COUNTY MEDICAL SOCIETY ON THE HONOR ROLL! PINELLAS COUNTY MAY WELL BE PROUD OF ITS RECORD OF 72 MEMBERS WHOSE DUES ARE FULLY PAID. THIS SOCIETY HAD THE DISTINCTION OF BEING 99% PAID AT THE LAST ANNUAL CONVENTION.

Dr. W. Lassiter, secretary of the Alachua County Medical Society, was a welcome visitor at the business office of the Association in Jacksonville September 24th. After looking over the official roster from his Society, memorandum was made of all members who have not paid their annual dues and Dr. Lassiter made a statement that the back dues would be forwarded at an early date. Dr. Lassiter, as city health officer, made arrangements through the State Board of Health to put on a whole-time nurse for Gainesville.

Dr. H. Mason Smith, president of the Florida Medical Association, has just returned from an extensive trip, having visited and studied in the clinics of Boston and Baltimore.

Mrs. W. Lassiter of Gainesville, president of the Ladies' Auxiliary of the Florida Medical Association, has just about completed plans for a new constitution for that organization, which is to be proposed at the next annual meeting. Watch the news column of this Journal for information concerning the Ladies' Auxiliary.

Dr. R. Hippensteel of Fort Lauderdale, former secretary of the Broward County Medical Society, has moved to Indianapolis, Ind., and has associated himself with Dr. L. Sejar.

Dr. R. F. McLeod was elected commander of American Legion Post No. 1 of Titusville on September 28th.

Following the recent storm in Pensacola, the members of the Escambia County Medical Society were quite busy rendering aid to all sufferers. Pensacola did not find it necessary to call for outside aid.

Dr. J. C. Davis and family of Quincy spent the month of August at Andrews, N. C.

Born to Dr. and Mrs. John R. Boling of Bradenton, a boy.

The city commission of Fort Lauderdale has organized a Board of Health.

Dr. James B. Parramore has recently returned to Jacksonville and opened offices in the St. James building after an extended absence doing post-graduate work in New York City. Dr. Parramore will limit his practice to oto-laryngology, bronchoscopy and esophagoscopy.

Dr. M. A. Lischkoff returned to Pensacola after spending the past four months in Vienna and London doing post-graduate work.

Dr. R. F. McLeod and Dr. R. D. Ferguson have opened a twelve-bed private hospital in Titusville. This is the first hospital to be opened in Brevard County.

Dr. Alvah Leo Rowe of Lake Worth was married to Miss Louise Virginia Conner of Enterprise, Ala., on August 11th.

The Board of Medical Examiners, working in conjunction with federal authorities, is exercising every effort to rid Florida of some of its "diploma mill" operators. Dr. G. A. Munch of Tampa was recently arrested by Federal authorities and placed under $5,000 bond. During past years, it is a well-known fact that many irregularities in the maintaining of licenses for practicing medicine in Florida existed. It is the sincere hope of all the members of the Florida Medical Association that the good work started by the Board of Medical Examiners will be carried to the point of ridding the state of all offenders.

When the editor of the Florida Medical Journal took over the Journal files at the beginning of his administration in 1925, the following Journals were missing:

1914—All issues.
1915—All issues.
1916—All issues.
1917—All issues.
1918—March.
1919—March, April, June, August, September, November, December.
1920—January, February, May.
1921—March, June, October.
1922—July, November.
1923—March, April, May.

As yet he has not been able to obtain them, and any member of the Association who can supply the editor's office with these numbers will aid us materially in our work.

Dr. H. D. Snyder, who has been in Atlanta at the bedside of his wife, has returned to Pensacola.

A called meeting of the Escambia County Medical Society was held at the State Board of Health Building at Pensacola, on September 9th. Dr. H. Mason Smith, president of the Florida Medical Association, was guest of honor and principal speaker of the evening, using "Organized Medicine" as his subject. Dr. Smith outlined the advance made during the past few years in obtaining legislation to abolish quackery and illegal practices and explained the bills which

will be brought up at the next session of the Legislature. In concluding, Dr. Smith suggested the consolidation of the Walton-Okaloosa and Escambia County Medical Societies. Following Dr. Smith's address, a few remarks were made by the other guests—Dr. J. C. Davis of Quincy, Dr. J. Q. Folmer of Chattahoochee and Dr. H. Palmer of Tallahassee. After the adjournment of the meeting, a light supper was served.

A meeting of the physicians of Okaloosa and Walton Counties was held at DeFuniak Springs at noon on September 9, 1926, and Dr. H. Mason Smith of Tampa, President of the Florida Medical Association, was guest of honor. Dr. E. Porter Webb of Crestview, Vice-President of the Bi-County Medical Society, presided. Dr. Smith was introduced by Dr. W. C. Payne as Councilor for District No. 1, which district comprises the counties of Walton, Okaloosa, Santa Rosa and Escambia. Dr. Smith made a very forceful address in which he stressed the importance of organized medicine. On account of the small number of physicians residing in Okaloosa and Walton Counties, it has been found impractical to have an active society in each county. Three years ago the two counties were combined into a Bi-County Medical Society and even then the number of physicians is not great enough to stimulate a great deal of interest. Dr. Smith stated in his address that he was making a survey of this district and that he probably would recommend the combining of the four counties into one society, this to be determined later. Dr. Smith had as his guests at this meeting, Dr. H. Palmer of Tallahassee, Dr. J. Q. Folmar of Chattahoochee, Dr. J. C. Davis of Quincy, Dr. Rufus Thames of Milton and Dr. N. A. Baltzell of Marianna. One hundred per cent of the members of the Bi-County Medical Society was present at the meeting. Dr. Smith and his guests left immediately for the meeting at Pensacola where they were entertained the same night at eight o'clock by the physicians of Santa Rosa and Escambia Counties.

HOLLOWAY: LEAD POISONING IN CHILDREN

(Continued from page 96)

But if you will examine it a number of times, you will almost undoubtedly get a positive report, so have three or four tests made. It is interesting to note that long after the clinical symptoms have subsided there will be an appreciable test for lead in the feces and urine. Of the two tests, the urine is more reliable and more satisfactory, because insoluble lead salts may pass through the bowel without being absorbed by the tissues. I feel that the bones will take up lead salts and hold it for a long time, and therefore that the test can be made best on the urine as a last analysis rather than upon the blood picture which is not absolutely typical, or upon the feces for the reason mentioned.

CONCLUSION.

Dr. L. W. Holloway, Jacksonville:

I have nothing further to add, but I want to thank the gentlemen who discussed my paper so thoroughly and nicely. I thank you.

ADVERTISERS' NOTES

SENSITIZATION

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

County Society	Secretary	MEETINGS				Dues Paid
		Date	Time	Place	Luncheon?	
Alachua	W. Lassiter, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	71%
Bay	J. M. Nixon, M.D., Panama City.					100%
Bradford	Seeber King, M.D., Lake Butler.					100%
Brevard	R. D. Ferguson, M.D., Titusville.	Varies		Varies		100%
Broward	Leigh F. Robinson, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Commerce	No.	100%
Columbia	L. J. Arnold, M.D., Lake City.					82%
Dade	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.	83%
Duval	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.	100%
Escambia	Herbert D. Snyder, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	67%
Four Counties..	G. C. Hardie, M.D., Ft. Pierce.					43%
Hillsboro	B. W. Lowry, M.D., Tampa.	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.	96%
Jackson	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.	96%
Lake	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	93%
Manatee	J. M. Davis, M.D., Bradenton.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.	90%
Monroe	G. R. Plummer, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	95%
Palm Beach ...	W. O. Arnold, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Monterey Hotel	Yes.	100%
Pasco-Hernando....	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.	86%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every 2nd Friday	8:00 P.M.	Fla. Art School	No.	100%
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	89%
St. Johns	I. M. Hay, M.D., St. Augustine.	3rd Monday	8:30 P.M.	Varies	Yes.	90%
Sarasota	F. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Second District County Medical Society	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	88%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	86%
Taylor	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	78%
Tri-County ...	I. W. Chandler, M.D., Avon Park.		8:00 P.M.	Varies	No.	87%
Volusia	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	88%
Walton-Okaloosa	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	88%

NOTE—(Secretaries: Please submit information to complete the above schedule.)

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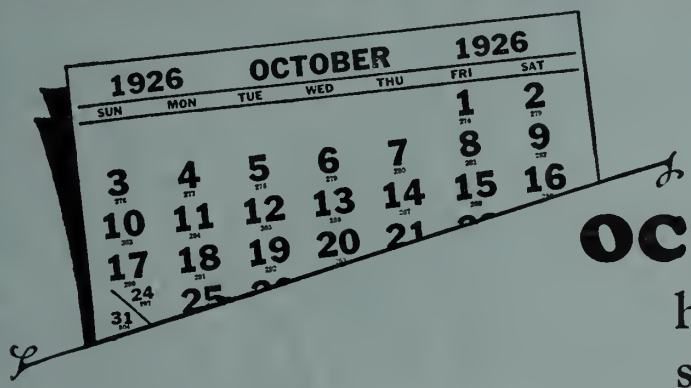
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CONTENTS

PAGE

Labor—Normal and Abnormal..... 102
S. R. Norris, M.D., Jacksonville.

The Early Diagnosis of Tuberculosis..... 105
W. A. Claxton, M.D., Miami.

The Causes of Insanity..... 109
W. H. Spiers, M.D., Orlando.

Immunization—Every Doctor a Health Officer..... 113
F. A. Brink, M.D., Jacksonville.

PAGE

Opportunities for Study in Vienna..... 115
A. K. Wilson, M.D., Jacksonville.

Editorials: (1) Membership; (2) Some Facts Concerning Cancer; (3) The Next Annual Meeting; (4) Medical Conference.....118-120

State News Items..... 120

Advertisers' Notes 124

Schedule of Meetings—Component Societies of Florida Medical Association..... 125

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LABOR—NORMAL AND ABNORMAL*

S. R. Norris, M.D.,
Jacksonville.

Mr. President and Fellow Members, Florida State Medical Association:

The title of my paper today was chosen advisedly. I have no original treatment or new technique to offer you. I did not want to bore you by presenting a collection of statistical reports or a long scientific treatise on some one complication of labor, which would be of academic interest only to a group of general practitioners. Medical literature has been full of such papers for the past several years. So I am going to discuss labor in general, take stock of our shortcomings, our sins of commission and omission, and ways of improvement.

Every year thousands of budding young lives are snuffed out that could be saved, or given stigma that follow to their graves. An appalling number of mothers are killed or invalided as a result of labor. Now we as physicians know that this should not be, that we are not guiltless. Some of this innocent blood is upon our hands. What are we going to do to erase this stain? Wherein are we culpable? In two chief respects: not doing the things we know should be done and are capable of doing, and attempting to do something we haven't the ability or training to do. Some of us belong to one category, some to the other. We must wear the shoe that fits. First let us discuss so-called "normal labor." Countless lives are lost from infection, for most of which we are absolutely to blame. We can not all be obstetric specialists or deliver all our cases in maternity hospitals, but we all can, and should, conduct labor as aseptically as possible. In brief, in some such manner as the following: Shave or clip the patient, scrub-up preparation, or paint with iodine or mercurochrome solution. Make minimum number of vaginal examinations, as morbidity and sepsis increase proportionally. Our own hands as clean as possible and protected by sterile rubber gloves, and throughout labor keep the field as protected and sterile as we possibly can. This seems elementary, yet every one of these simple rules are broken every day, and another fatality chalked against our ever-increasing total. Just a short while ago, I was called in consultation to a labor case in a home. As I walked into the room one physician had his hand in the woman's vagina up to the wrist without gloves, rinsed his hands in fresh tap water, reinserted his hand and began to apply unsterile forceps and pulled a posterior occiput through the perineum. When that man signed that death certificate, how could he sleep, or look that husband and motherless children in the eyes with a guiltless conscience? Similar cases happen every day.

The next essential in the proper conduct of a normal labor is that the attendant be present from the beginning of the second stage and continue in personal attendance upon the laborer until she is safely back from the delivery room. We are not doing our duty either to the mother or babe if we leave her in charge of a nurse or ignorant relative with the instructions to call us when the baby is ready to be born. We can never tell when some unforeseen complication may arise that necessitates immediate action to save a life, or that may cause a change in our plans of conducting the labor. It is not only essential that he be present, but the fetal heart sounds should be taken at frequent intervals, especially after the head reaches the perineum. This gives us the most reliable information concerning the welfare and condition of the fetus, as well as being useful in determining position and progress in rotation and descent. No matter how expert the attendant or how extensive his knowledge and his experience, he is of no avail to the suffering patient if he is not with her when he is most needed and is aware of the first sign of distress of the unborn babe.

There are about 300,000 stillborn children in this country every year, the majority of which die during labor. We cannot prevent these deaths over the telephone.

The third stage of labor, though short and simple, is a very important phase to the patient, and it is at this time that many mothers are infected or invalided for life. It is the prevalent idea of many physicians and most nurses, and practically all laymen, that all danger is over as

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

soon as the baby is born, and there is a general let-up in carefulness and break of technique by all parties concerned. Oftentimes a labor that has been conducted well throughout is most slovenly and carelessly handled during the third stage. Details of properly managed third-stage labor can be had in any standard text-book and will not be given here.

Probably our greatest mistakes and most glaring faults occur in the handling of abnormal labor. Among the principle reasons is lack of proper training among the average physicians in the handling of complications, needless interference in a normal labor, the inability to make the correct diagnosis until the patient is in extremis, and the reluctance to call in a consultant until after the case has been hopelessly bungled, or the most opportune time for action has passed.

Time will not allow us to consider every abnormality that may arise in labor, so we will just say a few words concerning a few obstetric maneuvers and operations. The reckless use of pituitrin in labor is one of the greatest offenders as it is so universally employed. Many babies are killed thereby, or crippled. A very prominent pediatrist of Jacksonville has collected a series of 27 cases in the past two years of convulsions in the newborn from brain hemorrhage, over 80% following pituitrin. There is the ever-present danger of a ruptured uterus, as well as an increase in the number of perineal lacerations. It is the consensus of opinion that pituitrin should not be used in primiparas before birth of baby and in multiparas only in selected cases with the head right in the perineum. I do not like it even then. Pituitrin helps the doctor, not the patient. It is usually an expedient to save the busy practitioner's time.

Forceps is both a blessing and a curse to suffering womankind, more often a curse in the hands of the poorly trained. Many infant lives will be salvaged, many mothers will keep their health following delivery, when there is some regulation as to the men privileged to use forceps. Many men who are not allowed and who would not dare to perform the simplest surgical operation in the average hospital are permitted and have the bravado to recklessly apply the forceps to a floating head or posterior occiput and to drag it forcibly through an undilated cervix or a contracted pelvis. What are we going to do about it? Much has been written recently as to the merits of the various types of forceps. To my mind this is secondary to the operator's skill and knowledge, the fundamental principles, indications and requirements of their application.

Another cause for our high obstetric mortality is the increase of Cæsarean sections, performed without proper indication. Quite commonly a man will section a patient when he is unable to deliver per vaginam because it solves a dilemma for him, extricates him from a bad situation. Yet this case might have been better handled in some other manner, probably a podalic version or forceps. The indication for a section should not be the surgeon's ability to perform it or the patient's ability to stand it but whether that is the most desirable method of delivery in that particular case. The low-cervical Cæsarean section as advocated by Drs. Lee, Hirst, and other prominent obstetricians, promises to give much better results than the old classic section, especially in the potentially infected cases. The old maxim that "the more Cæsareans, the less obstetive knowledge," still holds true.

Although eclampsia is largely preventable by proper prenatal care, there are still many thousands of lives lost each year. I mention this condition here in connection with Cæsarean section to more forcibly condemn it as the routine method of handling these cases. Much better results follow more conservative management and we should regard it as a medical rather than a surgical complication. The riddle of eclampsia is still unsolved, but statistics overwhelmingly prove that routine Cæsarean section is not the method of choice unless there is some other indication for its performance. Personally, I have handled only about 15 eclamptics, all referred; I am glad to say, too small a number to prove anything, but I have sectioned none of them. All the mothers got well and all the babies that were alive when I saw the patient. Some induced with bags, some by version, forceps and natural delivery, elimination, narcosis, magnesium sulphate, and general conservative treatment.

The various complications, such as placenta prævia, posterior occiput, contracted pelvis, etc., all give us better results when the average physician becomes more adept in diagnosis, more willing to refer these cases to a man better trained to handle these abnormalities, when he is not equipped to do it properly himself.

In conclusion, we can safely say that to lower our obstetric mortality, we must have more extensive training in the handling of normal cases; that the attendant be with his patient during her

second stage and be aseptic; less interference in normal cases; more conservatism rather than radicalism in obstetric surgery; and finally to educate the public and train the physicians to refer the complicated cases to a maternity center when they do not possess the needed skill and experience.

DISCUSSION

Dr. T. S. Field, Jacksonville:

I want to congratulate Dr. Norris on his attempt to get the doctors who are practicing obstetrics to practice better obstetrics.

There is one thing that I want to emphasize about better obstetrics that he did not put enough emphasis on. Obstetrics is a surgical procedure, and there are men who would not attempt to open an abscess in a private home that would hasten to do obstetrics in private homes. And it is my personal opinion that all obstetrics should be done in the hospital, and I personally do not attend any patients except in the hospital. If they won't go to the hospital they have to get another doctor.

I have had very satisfactory results with the use of mercurochrome as an antiseptic. I do not believe in scrubbing patients. The patient is shaved, and when you scrub them you just wash all the dirt and bacteria about the vulva into the vagina. I want to severely condemn scrubbing patients. You don't scrub operative patients, you paint the abdomen with iodine or mercurochrome solution and let it go. And there is no reason for scrubbing an obstetrical patient. Shave the patient and paint with mercurochrome 2 to 4%, and particularly before every vaginal examination we make a practice of injecting 1 oz. of mercurochrome solution into the vagina. I have had no infections since starting that. All my examinations are vaginal. The chief technique used in obstetrics is haste. A patient is brought to the hospital and then put in the delivery room and pretty soon somebody sees the head, and they all rush to call the doctor. The doctor looks in, sees the head and sometimes does not have time to scrub. Most of the time just puts soap on hands, rubs it off, and runs in to deliver the patient. Every doctor should scrub as carefully for obstetrics as he would for a major abdominal operation, but that is not done. And that is where infection originates, to my mind.

Now, about Dr. Norris' statement of the attendance upon the whole second stage of labor. That is a pretty hard problem, gentlemen. The patient that will pay you $250 to $500 for spending fifteen minutes taking out an appendix will have you put in jail if you charge $100 for delivering a baby where you stay up all night. Babies don't choose the time to come. They may come in six hours or they may come in the middle of the night in two or three hours. You cannot be present at the whole second stage of labor if you are going to do much operating and any work besides obstetrics. I am perfectly willing to send my patient to the hospital, go out and examine and find out where she is, and then trust the trained nurse in charge of obstetrics out there to let me know how the patient is progressing at intervals. It is very nice to stay there during the whole second stage, but I don't think most of us can afford to do that.

I fully agree with Dr. Norris about the third stage of labor. Most men, as soon as the baby is delivered, are in a hurry to start the Crede method. Now they might just as well wait fifteen or twenty minutes and give the placenta a chance to deliver itself without trying to push it out of the uterus. Almost every patient has some laceration of the cervix, I don't care what care you use in the delivery of that patient. I have seen too many patients post-partum, both my own and others. Although almost every patient gets some degree of laceration of the cervix, and sometimes this is a severe laceration, most delivery rooms are not equipped to take care of these lacerations of the cervix. There is some suture material there, a needle holder and some needles but no speculum and no vaginal forceps or anything else to take a look at the cervix and see how much laceration there is and how much repair is needed. A great many infections that you get with labor come from lacerations of the cervix which have not been attended to, and a good many severe hemorrhages that put your patients in shock come from that very same cause. Lacerations of the cervix are almost universally overlooked while lacerations of the perineum in the hands of any fairly competent man are easily repaired.

I agree with Dr. Norris about pituitrin, with one exception: There are patients who in the second stage of labor have a hard time and they get inertia. I believe that 3 mm. of pituitrin when the cervix is fully dilated in cases of inertia is better than forceps because you never know how much pressure you are putting on the hand with forceps. I personally never use high for-

ceps. Cæsarean section, it is true, is very common nowadays, and too common, but I would much prefer personally that a Cæsarean section be done on my wife, if she had a floating head, than a version or high forceps. And I expect to continue to do Cæsarean sections on that type of cases the rest of my obstetrical life unless I see something that radically changes my mind. I have used magnesium sulphate in two cases, the last one last week. One injection of 25 cc. of a 10% solution reduced the blood pressure, within thirty minutes, twenty points. The patient had blood pressure of 186, urine filled with albumin, severe headache. I have found magnesium sulphate to be very useful.

CONCLUSION.

Dr. S. R. Norris, Jacksonville:

I agree with Dr. Field; I did not mean that Cæsarean section should never be done. In cases like that it is indicated. I never use high forceps.

About staying with the patient: It is hard for the men doing general practice, but nevertheless it is essential. Time and again you cannot trust the nurse to tell you when you should do something to help the patient along. You stay home during second stage and wait for the nurse to call you—you are nothing but a midwife. Anybody can tie the cord. I had two cases within one week which illustrated the necessity for close attendance. I know it saved the baby's life. In one case the cord was eleven inches long. The patient had had a perfectly normal labor. The heart sounds were normal and ten minutes later, with the head on perineum, heart sounds stopped. Delivered with outlet forceps. If I had been waiting for that nurse to call me the baby would have been dead. Now, the baby is all right. The other case was a multipara. The child was delivered by podalic version and weighed nine pounds. This patient had measurements larger than normal, went into labor, cervix completely dilated, yet the head had not engaged. We took her upstairs and did a version. She had an extra promontory which could not be reached by ordinary examination at all. Cord was prolapsed and would have come down with first pain after rupture of membranes. That baby would have been dead also. She would not have progressed at all.

What is ideal cannot always be done, but as far as possible should always be done. That is the idea of sending patients to the hospital. Personally, I do not do work at home. But it has to be done when there are no hospitals.

Cæsarean section is not always indicated on floating head. Indication depends on what is the cause of floating head. If contracted pelvis or disproportion, Cæsarean section may be indicated, but if from hydramnios or bad position a version may be the better procedure.

Although it is ideal that obstetrics should be done in the hospital, many cases in the rural communities will continue to be delivered in the home, so it is necessary that the doctors, themselves, be better trained in obstetrics.

THE EARLY DIAGNOSIS OF TUBERCULOSIS*

W. A. Claxton, M.D.,
Miami.

The reason for presenting a paper on this subject is not only to describe the methods of arriving at an early diagnosis of pulmonary tuberculosis, but also to enlist the interest of the practising physician in the control and ultimate eradication of this plague. The general practitioner has the best opportunity to make this early diagnosis. He knows the family history, the environment and personal habits of overwork or dissipation of the majority of his people. In a word, he is the pivot around which any antituberculosis movement must function.

That tuberculosis is a curable disease is becoming more and more an authenticated fact, as we see proofs of permanent recovery in people who have taken "the cure" early and persistently. The underlying principle of "a successful cure" in tuberculosis is EARLY DIAGNOSIS.

To make a diagnosis of tuberculosis in a fairly early stage of the disease, a careful routine of history and examination should be followed. A careful history is of at least as much importance as a careful examination, especially in offering a prognosis.

First one should try to elicit a history of exposure. The old theory of heredity, per se, is no longer held. Children born of a tuberculous mother are not tuberculous at birth. What does predispose to a tuberculous child is that the child, after birth, should associate with an active case of tuberculosis. This may have been a father or mother or other adult in the household, or it may have been a nurse or other attendant. Many instances are at hand where a whole family of children have become infected by the family nurse

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

who had charge of them in infancy. In other words, intimate contact is the important cause of infection. In line with this inquiry into possible contacts, the facts regarding deaths in the family should be ascertained. If a member died from a chronic illness where chronic cough was a symptom, that fact is important even though the diagnosis of tuberculosis was never made. Patients will say that a member of the household died of pneumonia, and when questioned closely will say that the deceased had been feeling badly for a year or more. This fact would arouse a strong suspicion of death from tuberculosis. A history of poor childhood environment with insanitary surroundings, poor food and hard work during the growing age is significant.

Ask about former diseases: adenitis, scrofula, fistula, bone and joint affections, typhoid, rheumatism, malaria, hookworm, operations, and traumatism. A former attack by any of these may predispose to tuberculosis. Especially important is a history of frequent colds, catarrh, nose and throat operations, mouth breathing, pneumonia, pleurisy, grippe and asthma. The first symptoms of tuberculosis may date from an ether anesthetic.

SYMPTOMS.

We come now to the symptoms of early tuberculosis. The most common early symptom is a slight cough which does not respond to treatment, but lasts for some weeks or which may be intermittent over a longer period. Before this, however, the patient may have experienced a feeling of unwonted tiredness, coming usually in the afternoon with weakness and sweating on slight exertion. There may be a story of loss of weight, loss of appetite or slight indigestion, pleurisy and dyspnœa. Hæmoptysis or blood-spitting is a sign of tuberculosis until proven otherwise. Pain in the chest or shoulder should not be passed off as rheumatism or neuralgia as it may be pleurisy around the apex. Fever is not often discovered without the use of the thermometer, but patients may notice a flushed feeling in the afternoon. The examination of sputum is especially to be mentioned. The presence of tubercle bacilli in sputum is, of course, positive evidence of the disease. Negative sputum, on the contrary, is no evidence one way or the other. Many cases of advanced tuberculosis do not show tubercle bacilli in the sputum, so this should not, as is often the case, be relied on to say whether or not a patient has tuberculosis.

PHYSICAL EXAMINATION.

Any patient who is to have a chest examination should be stripped to the waist.

INSPECTION.

Begin the examination by INSPECTION. Standing four to six feet from the patient in a good light, observe first any indications of abnormalities in facial contour and expression, as sunken cheeks, flushing over malar bones, evidence of defective nasal breathing from adenoids or other causes. In the neck region, look for enlarged cervical glands or evidence of their removal, enlarged thyroid, and abnormal pulsations. Are the head and neck held in such a position that one would realize that the patient was trying to straighten the line of his trachea? Are the muscles of the neck prominent or atrophied, especially unilaterally? Is one shoulder lower than the other? In an early lesion, the shoulder on the affected side may be raised by spasm of the muscles. In an old lesion, the shoulder on the affected side will be lowered from atrophy or fibrosis. Does the chest expand equally on both sides? This may be observed better from behind. The affected side will show diminished expansion, diminished motility of the shoulder and sometimes a retraction of the intercostal muscles. With the patient's chin lowered on his sternum, look over his shoulders with both eyes and note any difference in the time of appearance of the pectoral muscles on deep inspiration. The side showing diminished expansion will be the affected one. Look for a difference in the prominence of one clavicle or scapula. The prominence will be greater on the involved side due to atrophy of the muscles.

PALPATION.

Feel for unequal tenseness of the muscles on each side of the neck and upper chest. Now with the palms of the hands or tips of the fingers on relative positions of the patient's chest, ask him to speak "99" and note any difference in vocal fremitus. This is normally a little more marked on the right.

PERCUSSION.

Begin percussion at the bases of the lung behind. Note the level of the diaphragm on each side. A raised diaphragm on one side will indicate a drawing up on the affected side from adhesions, old pleurisy, or dullness from the presence of fluids. Having percussed the bases, continue towards the apices on each side, and note presence and extent of comparative dullness.

On the front, begin percussion on the right side about the level of the fifth interspace as this is most often a normal resonant note. Percuss with the finger in the intercostal space held parallel to the ribs.

AUSCULTATION.

Begin by listening to ordinary respiration, noting intensity of breath sounds, prolonged expiratory sounds, harsh breath sounds and pleuritic rub. Next ask the patient to breathe deeply. This will bring out the same diagnostic points more clearly, and will sometimes arouse a suspicion of cavity, consolidation or fluid in the chest. Do not hurry in an examination; if the patient complains of dizziness, let him rest, but do not cut short the examination.

Now ask the patient to whisper "1-2-3" repeatedly and go over the chest with the stethoscope. An increase of the sound of the whispered voice will indicate involvement, usually consolidation or cavity. Diminished whispered voice would indicate pneumothorax or fluid. Ask the patient to "breathe out, cough, and breathe in" while the chest is gone over. The typical medium rale of early tuberculosis is heard just after the cough at the beginning of inspiration. RALES WHICH CAN BE HEARD ON ORDINARY OR DEEP BREATHING WITHOUT COUGH ARE PROOF OF ADVANCED DISEASE. Rales heard at the base may be confusing. In the first place, one may find rales which are due to the separation of the margin of the lung at the diaphragm, and in the second place, rales at the base are not an indication of tuberculosis unless other definite proof is furnished, as positive sputum or cavity by X-ray. On the contrary, rales at the apex are tuberculous unless proven otherwise.

Have stereoscopic X-ray plates made when possible in early cases. They not only confirm the diagnosis, but also may be compared with later plates as a guide to improvement or retrogression. A single flat plate is not of much value.

CONCLUSION.

1. In diagnosing tuberculosis, take a careful history and consider the predisposing factors.

2. Develop the faculty of observation by inspection.

3. Do not consider an examination complete until rales after cough have been tried for.

4. Do not place any reliance on a negative sputum report.

5. Do not diagnose tuberculosis from rales heard at the bases. These are generally from bronchitis.

6. Hæmoptysis is from tuberculosis unless proved otherwise.

7. Do not be content with one examination in a suspicious case. The Veteran's Bureau requires a month's observation before ruling out tuberculosis.

8. Have stereoscopic X-ray plates taken when possible.

DISCUSSION

Dr. A. F. Higgins, Tampa:

I am very much interested in Dr. Claxton's paper on the early diagnosis of T. B. I have not much to add to what he had to say, but I concur in everything that he did say.

Taking into consideration the early diagnosis of T. B. we have a number of factors that Dr. Claxton did not mention. As you know, the general public as well as the physician needs considerable education along this line. The case that we ordinarily see in our office is not the early case of tuberculosis. They don't come to us early enough for their diagnosis. And many of them do not come to the office until somebody has found a positive sputum. If we would commence and educate our public to go to a competent man for diagnosis early in the disease, the problem that we have to deal with would be very much better.

In the early diagnosis of tuberculosis the most important consideration must be the history, and in taking that history every endeavor must be made to find the time of contact of that patient with some tubercular individual. After we have found the date of contact, the next point to be determined is when that case became active.

We must realize always that there are three factors that are most important in the activity of these cases. The first is other wasting disease, second starvation and third dissipation. Taking these three you can very easily at times determine when that case became active. To make this very brief, I wish to just simply state five points, each one of which is diagnostic of tuberculosis, whether it be in the early stages or the last stage.

The first consideration after the history in the diagnosis of a case from a clinical standpoint is by inspection and palpation of that case. You will be absolutely surprised at the number of cases that will come to your office and, as soon as they are prepared for examination, by inspec-

tion alone you can determine exactly where the lesion may be located. By palpation the lesions are many times plainly located before you touch them with a stethoscope.

There are five points I always take into consideration in making a diagnosis of tuberculosis. First, rales in the upper part of the chest. These rales must be persistent rales. In other words, that means that you cannot make your examination of that patient complete in one day. A man who is doing tubercular work cannot make a complete diagnosis of a beginning or a first stage case of tuberculosis without keeping the patient under observation for several days. It is important that your diagnosis be positive. The second, which is absolutely diagnostic, is hæmoptysis.

In taking your history it is extremely important that you get a history out of your patient that they are spitting blood. It is surprising how many times a patient will conceal from you the very fact that they have been spitting blood. Hæmoptysis is absolutely diagnostic of tuberculosis. The third point that we take into consideration is positive X-ray findings. The fourth is fluid in the chest cavity. As I have gone over this work in the last ten years I have been more and more impressed that wherever you find fluid you are absolutely sure you are dealing with a tubercular case. The fifth point I have purposely put last, viz: Positive sputum. The negative sputum is the rock upon which many tuberculars lose their lives.

The State Board of Health sends out a warning on each one of the little slips with the reports. When that report comes back negative, very frequently the patients are not informed as to what the State Board of Health has to say on the reverse side of that slip. There are many cases of tuberculosis that never have a positive sputum, but they can be just as easily diagnosed. You will frequently find one of the four points present. The positive sputum is always T. B. The negative sputum is a doubtful one. And, gentlemen, I think we need some education for the general public along that line, and I am very sorry to say that many times the general practitioner also needs to be educated. In closing the discussion I wish to simply state that we must be very careful about negative sputum.

Dr. Hewitt Johnston, Orlando:

I want to say just one word in regard to educating the public. In the past, physicians—though not so much now as formerly—have been too secretive: that is, concealed from the patient the idea, and from the parents the idea, that possibly that child or adult may have tuberculosis.

I think if we will be more frank and always inform the party or family promptly that we suspect tuberculosis, not hold it from them, but emphasize the fact that it might be, and if it is, the sooner they know it the better for all parties concerned, we shall have gone a long way in educating the public in the right direction. This is the point I want to emphasize.

CONCLUSION.

Dr. W. A. Claxton, Miami:

I agree with the last speaker in that you should not conceal from a patient the fact that he has tuberculosis. I have seen several cases that have had what would be considered definite signs of T. B., for instance fluid in the chest or probably rales, enough to make a tentative diagnosis at least—in their cases definite diagnoses, and the doctor had let those patients go along for months without telling them that they had tuberculosis. Now, that is a bad mistake because you lose time that is valuable toward curing that patient. And we might say, as a general rule, that every month that patient is away from taking the cure would mean from four to six months longer time taking the cure after he had got on it. So that it is rather a hardship on the patient to let him go along not knowing that he has T. B. and therefore not taking the proper precaution all of these months.

Another point that was brought out was the importance of the history. Now, the history of course is very important, especially in the prognosis, because the further back you trace tuberculosis in the history the better prognosis for the patient. A patient comes to you that has had tuberculosis for eight months or a year; that patient's prognosis is not as good at it would be if that patient had had tuberculosis for ten years, because when a patient comes to you who has had tuberculosis for ten years and is in fair condition, let us say moderately advanced, we know that that patient has fought off this disease for ten years and therefore his resistance must be fairly good. Whereas if a patient comes to you with definite symptoms for eight months and is in about the same state of health with some temperature, loss of weight and other symptoms, that patient has not the same resistance as the man who has had tuberculosis for ten years, and therefore you cannot make so good a prognosis.

THE CAUSES OF INSANITY*

W. H. Spiers, M.D.,
Orlando.

Probably no question is more frequently asked than the one, "What is the cause of insanity?" While this is not easily answered, I will endeavor to give you the results of my observations over a period of about ten years of actual contact with mental conditions. It has been a subject of much discussion. This is not a discussion, only a statement of facts as I am able to see them.

The causes of insanity are as various as the causes of fever, and in this we have to consider both the predisposing and exciting causes.

The predisposing causes are those conditions existing in the individual which render him liable to the development of mental disorders under favorable circumstances. The exciting causes are those circumstances and conditions which produce the actual attack operating upon predisposal soil always.

Heredity is variously estimated by different authorities on the subject as, predisposing cause in from 30 to 90% of all cases. But anyone familiar with the collecting of statistics must know how impossible it is for them to fully represent the facts in such matters. It is quite impossible to procure a complete family history in many instances, and I am inclined to believe that were it possible to obtain all the facts relative to heredity as a cause, 90% would not be an exaggeration.

In any table giving the causes of insanity we will find ascribed such causes as "Loss of property," "Business worry," "Disappointment in love," "Death of a friend or relative," "Political or religious excitement," and "Domestic troubles." How many of us are there who have not at some time suffered from some, or perhaps all, of these so-called causes of insanity? A noted psychiatrist says very forcibly on the subject, that substantially every individual at some time during his life is exposed, in many cases repeatedly, to many of the so-called causes of insanity, both mental and physical, and yet despite this fact, we find that sanity is the rule and insanity the exception.

In ascribing these causes, while they may have contributed to the actual attack, and thus operated as exciting causes, the much more important condition was overlooked, which was the unstable make-up of the individual which made it possible for such conditions to operate at all, as causes.

The average, or normal, mind under the influence of stress does not become deranged unless from operation of traumatism, extreme toxemia and exhaustion, and not even then with anything like the facility of the mind predisposed to disease by constitutional or hereditary taint.

Taking up the various factors attributed as causes of insanity: First, syphilis, generally considered by the laity as the greatest cause, but actually there are only about 10% of all the cases of insanity which can be traced back to syphilis. About 6% of persons having syphilis develop insanity, the majority of these being paretics.

These figures are gradually being reduced, due to better methods of treatment and prevention and greater laboratory facilities for the detection of syphilis before it is too late. Even syphilis does not as easily produce a psychosis, in a normal individual, as in one already constitutionally inferior. I have, in my experience, known of several cases of paresis developing in individuals with a very bad family history of a psychotic tendency.

Next, I will take up tuberculosis, and here I must admit that this malady is either directly, or indirectly, responsible for more functional psychosis than any other condition. I arrived at this conclusion years ago, after discovering so many cases of tuberculosis at the State Hospital. We have there one of the best equipped tubercular sanitoriums in the South. Since that time I have always inquired very closely into the family history, or the patient's contact with tuberculosis, and in no single instance have I failed to find enough evidence to at least associate this condition with it.

There is something about tuberculosis which has a tendency to weaken the reproductive powers of the individual, and there is something about the toxin produced which has a special affinity for the nervous system. In any case of active tuberculosis one has, at some time, a neuritis of varying degree. Practically all of these cases are subject to the functional neuroses.

The various toxic conditions, both endogenous and exogenous, have been under investigation as a cause of insanity and very little so far has been gained. The endogenous, comprising mostly the endocrines, in my opinion, are the most impor-

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

tant, but so far our knowledge of the internal secretions is very limited. However, I frankly believe that our greatest hope in the treatment of functional psychosis lies in this direction.

The exogenous, comprising the various focci of infection, intestinal auto-intoxication, (and you might include other toxic agents), merely aggravate an already existing condition. In other words, no one ever developed a psychosis from these toxic states unless predisposed to it. In many of the borderline cases we have psychotic episodes produced by these toxic states which are amenable to treatment, but wherever you have a predominating toxic condition there is bound to be an element of delirium or confusion.

Alcohol, as one of the so-called ingested poisons, plays a very small role in the etiology of insanity. I believe that it never does so directly. Inebriation is more often the result of a beginning psychosis. Think of the thousands of people, even about whom we know nothing, who drink continually and, as I have said, even among them sanity is the rule, and insanity the exception. It is quite common for dementia præcox and paresis, and even manie-depressive cases, to begin following a period of debauchery. But, even in these cases, alcohol could not have been the cause. I do not wish to go on record in defense of alcohol, but I believe in adhering to facts, especially where there is so much contradictory evidence, as is usually presented by those already prejudiced. Therefore I must allow alcohol the benefit of the doubt, at least until I have more conclusive evidence of its guilt. I will admit that alcohol plays the important part in Korsakoff's psychosis and multiple neuritis, but consider this: Some will develop these conditions with very little alcohol, while the great majority can drink barrels, or rather drink over a quart a day, over a period of years, without any apparent ill effects. Then some other agent, toxic or otherwise, coupled with alcohol, must be necessary. Making this paper as brief as possible, I cannot linger too long on this very interesting subject.

Tobacco. "The sins which have been committed in your name." Aside from being a very, very mild stimulant and merely a comforting habit, I have yet to discover any condition which I can actually lay at the door of nicotine. It is accused of causing myocarditis, yet how many thousands of inveterate smokers there are who live to a ripe age without myocarditis, and how few cases of myocarditis use tobacco. If a thorough investigation is made one will invariably find some focci of infection, such as teeth, tonsils, etc. This is a little off the subject, but what one of you can positively say, after exhaustive search, that tobacco was ever responsible for any condition? I have read many commitment papers, especially of cases of dementia præcox, giving as the cause "smoking cigarettes," but, in every case, there was a strong neuropathic or even psychopathic family history, which eliminated tobacco as a cause, and throughout my experience I have yet to see the first case of insanity which was in the least the result of using tobacco in any form.

I will next take up the so-called mental complexes. A great deal of what heretofore has been regarded as constitutional, that is, hereditary, is now regarded by psycho-analysts as quite possibly individual and due to causes which are at least preventable. The presence of unconscious complexes causes reactions which seem to be constitutional, because their real cause is buried.

Now this is the view taken by many men whom I believe have become a little enthusiastic on the subject. There is no doubt that mental complexes very often cause slight deviations from the normal, and are manifested in abnormal behavior to a certain or slight degree. Such, for instance, as phobias, little mannerisms, forgetting of names, sudden impulses, but never reaching the degree where it could render one unable to adjust himself to ordinary environments or social usages. In order that mental complexes produce a psychosis it must act upon predisposal soil. They do not produce a psychosis in the average normal individual.

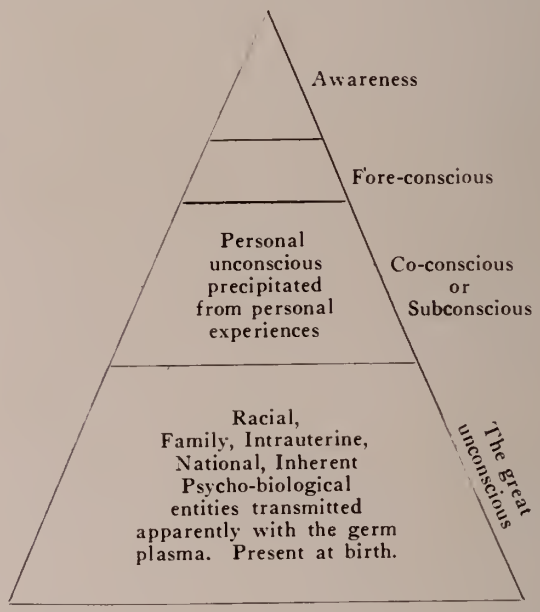
In conclusion, eliminating syphilis, which produces an actual brain lesion, and a few cases of traumatism, I must say that insanity always develops in one constitutionally predisposed. But I will say this: I believe even in some children born of parents constitutionally inferior, that, if perfect care was taken of them, giving them proper nourishment, stronger, better individuals might be produced and the species might overcome the family tendency in a few generations. Guard against the intermarrying of epileptics, those with a neurotic tendency, such as hysterias and those known to have psychotic tendencies. And as far as possible, stop the propagation of the constitutionally inferior.

DISCUSSION.

Dr. G. H. Benton, Miami:

In discussing this subject I think I shall devote these five minutes to the discussion of the subject rather than the discussion of the paper because Dr. Spiers has pointed out very largely many of the things that influence our psychotic conditions. Insanity, you all understand, is not the medical term but only a legal one and expresses nothing.

The causes of these developed psychotic conditions outside of the organic factors are quite multiple and yet they can all be expressed in two things—personality and environment. It would require volumes to express all of the components that occur to produce these actions and reactions and their control. It is quite impossible to do more than point out some of the factors that have to do with the resulting situations. I would like to call your attention for a moment to some of the things that constitute personality, and in these things I must call your attention particularly to that part of the nervous system that has to do with the self-preservation and longevity of the animal as a machine, or the machine as an animal, whichever way you care to put it. Superimposed over this part of the nervous system is our intellectual capacity. The action and reaction between these two parts of the nervous system are more in proportion to the education, training, accomplishment, and all of such things. Now, I should like if I can to put a diagram on the board which will give you an idea of the things that perhaps influence the personality. We will say that the whole mental condition can be represented by a circle, but I prefer to draw in this circle a triangle. While our conscious mind receives all of the impressions made, everything that happens makes an impression on the mind, not on the brain, and this is the point of entrance (demonstrating). These impressions gradually work down into the lower stratus, into the subconscious, co-conscious, unconscious, or whatever you desire to call it. These parts of our mind are filled up with our own personal experiences. Below this is the great unconsciousness in which we bring with us at the time we are born our hereditary psycho-biological entities—our personal and family characteristics, racial characteristics, etc. It is this part of the unconsciousness that forms the foundation for all of the great superstructures. Surrounding all of this in the triangle we may think of our intellectual capacity which has to do or should have to do with controlling the functions that arise from indistinctive proclivities. This is the basis of our personality, and as such our personality is represented in just the proportion that we control our instinctive desires in the direction of gratification. That is done largely by our intellectual capacity, by our training. It is evident then that psychosis is caused by organic irritation, for instance where there is destruction of cerebral tissue, the psychotic symptoms being expressed absolutely in the personality habits of the individual. One man reacts in one way and another in another, while the cerebral conditions are very much the same. You will understand more clearly from this explanation, as your psychosis is simply an alienation of your intellectual faculties, and when these let loose the function is comparable to that of an automobile which has no perfect control other than through the steering wheel, and the man who attempts to guide that car with his hands on the steering post alone without the wheel is not going to succeed very well, but is going to run into a good many difficulties.



The great unconscious is the foundation upon which the whole superstructure is constructed.

After William A. White.

Now, there is a situation: All personal peculiarities and all personal accomplishments influence this situation in one way or another. To be sure hereditary factors and all these things that influence personality have very much to do with the cause of our psychosis. The difficulty of course and the reason that we have such an

extensive amount of psychosis prevalent through the land is because of a lack of understanding of its basic principles and a lack of adequate teaching of the fundamentals of mental hygiene.

Dr. John D. Gable, Lake City:

Inasmuch as this meeting is about to close and there are only a few of us present, I thought I would like to help Dr. Spiers out by endorsing his paper and adding a little bit of suggestion to one or two points that he had only time to touch upon.

As he says, why does one man go through with a series of experiences and come out just as he went in or better, and another break down? More probably there was some difference before they went into the situation. Now, what that difference was we still don't know. The best thing that we can do now is to always ask ourselves, when we have a patient before us, how much of this trouble can I find in this individual, how much of it is before me now, and how much have I got to look for elsewhere? We should find out everything we can out of the individual we have before us.

Then the next important question is, which is the cause and which is the effect? We say this man is crazy. He is drinking a great deal of alcohol, has gone into it excessively. Was the alcohol the cause of the insanity, or was the insanity the cause of his drinking too much? The same applies to all other things. When you take this question up with the individual before you, you will then no doubt know which is the cause and which the effect; therefore, each case must be considered individually. It makes an interesting standpoint from which to study the situation.

As the Doctor intimates, many cases are due to organic disease, but organic cases can be worked out and don't present that difficult problem in closing in on the right diagnosis.

In a legal sense, the difference between a sane man and an insane man is that the sane man manages to get along with the things about him, and the insane man cannot. He does not fit in. He thinks they are crazy and they think he is crazy. They really feel that way about it.

As a matter of fairness, before saying that a patient is morally guilty, we should determine which is the cause and which is the effect in an individual case.

Dr. Mehaffy, Miami:

The cause of insanity is one of the most misunderstood things that the medical profession has to deal with, I believe. In the first place those of us who have lived in a hospital for insane have occasion sometimes to wonder how a medical man could have such a vast misunderstanding of what an insane person is like. And yet you can live from day to day and week to week among the insane and frequently not feel much different from what you do among a good many of your neighbors. In fact, you feel almost as if your patients are better than some of your neighbors—one inside and the other out.

I would like to get one or two things right, and that is simply this: That the question of insanity comes back to the simple biological fact of reaction on the part of the individual to his surroundings. The success or failure of any animal or any live plant or animal depends upon the successful reaction of this individual to its environment. And a person is insane only when his reaction to his mental environment (or so-called mental environment) becomes such as to make him undesirable or unsafe for the circumstances with which he must live. An individual who might have to be committed from New York City might live with perfect comfort and ease in a small community because the demands are not so great. It is just the same as an old tire which will give trouble on a dirt road, and yet you will be able to get a good many miles out of it if the same tire is put upon a hard road.

Now, then, the question was brought up, why one man becomes insane under circumstances that seem identical with another person who did not go insane. I have in mind now a trip that I made across country in which I put on four tires; two were cheap tires and two good tires, yet one of the cheap and one of the good developed stone bruises. The other two did not. Yet they were on the same road, everything the same, but it must not have been; it could not have been. There are various factors that cause strain in life, strain and emotional conditions.

One point: I think the off-set of the mothers the most important thing that you can do with making a good child and useful citizen; begin with it then and carry it out through life. The results are really wonderful. I say that for the reason that the same mother who has the will power to nurse her child regularly has the will power to teach this child regular habits, and to adjust itself properly to environment. Any of us who have worked in insane hospitals have seen the result time and time again when delinquent children were brought into the hospital,

because it was not prevented at the proper time, but were started with the wrong education and invironmental conditions.

CONCLUSION.

Dr. W. H. Spiers, Orlando:

There is very little to add, as everyone has practically agreed with me in my opinion of these cases.

Perfectly normal individuals are able to exercise the proper judgment in a complicated situation, but the abnormal man cannot.

One doctor brought out a very good point there: In children, routine I think is one of the greatest things in the prevention of mental disease. Especially is this true in people who are inclined to have a tendency to psychosis. You take a child that you suspect of a bad hereditary trait or possibility of psychosis, and bring that child up through life in the proper routine, very likely you will prevent psychosis.

IMMUNIZATION
EVERY DOCTOR A HEALTH OFFICER

F. A. Brink, M.D.,

Director, Bureau of Communicable Diseases, Florida State Board of Health.

Jacksonville.

So keen has the interest of the public become in preventing disease by active immunization with toxins, bacterian and attenuated virus, and so frequent are inquiries regarding their administration and effects received by the State Board of Health from members of the medical profession and laymen alike, that a free discussion of the subject seems timely. The writer, at every opportunity, fosters and commends the attitude of the practitioner who has the interest of his patients and community at heart to such a degree that he shields them as much as possible from preventable sickness.

It is the policy of the State Board of Health so to isolate each communicable disease patient that infection will not spread. This is impossible without the aid of the attending physician, who can give the necessary instructions in a few moments, and at the time when it is most necessary.

DIPHTHERIA.

Diphtheria patients and carriers should be placed in isolation and kept until two consecutive specimens from the nose and throat have been examined by a competent bacteriologist, and no Klebs-Loffler bacilli found. Other members of the family should be forbidden to mingle with the public unless they are entirely separated from the patient, and have a negative culture from the nose and throat. Children from the household should be excluded from school unless transferred to another house after the negative culture. The breadwinner, unless he is a food handler, is permitted to continue his work, if his culture is negative.

Cultures from the noses and throats of contacts in the house as well as in school will serve as a valuable guide in the management of children so examined. Carriers should be isolated unless the organisms are tested and found to be non-virulent. It is seldom if ever necessary or advisable to close school on account of diphtheria. The disease does not spread rapidly, and there is often less exposure in school than in the streets. The common drinking cup should, of course, be forbidden.

SCHICK TEST AND TOXIN ANTITOXIN.

If the doctors would see that all babies get the three injections of toxin antitoxin mixture by the time they are one year old, diphtheria would soon be a very rare disease. The interval between injections may be from five to fourteen days, preferably seven to ten. Children under one year should have one-half cubic centimeter (8 minims), over one year, one cubic centimeter (15 minims). The injections should be made, like those of typhoid bacterin, under the skin and over the deltoid muscle. The administration of toxin antitoxin, without the preliminary Schick test, to children under six—or even to older children in certain instances—is justifiable, but children of school age should be tested when they can be reached in groups and tested without the expenditure of too much time.

A small number, five or ten per cent, of those treated do not acquire immunity, hence the injections should be followed, after a suitable interval, with the Schick test if there is opportunity.

The immune reaction following the toxin antitoxin injections does not develop in less than six to twelve weeks, sometimes longer; the treatment is, therefore, not to be depended on for immediate protection. Children intimately exposed should be cultured, carefully watched and treated promptly with antitoxin if symptoms appear. Because of a natural or acquired immunity many exposed children escape the disease; for this reason, and because there is some danger of sen-

sitizing and anaphylactic shock if serum is given after an interval of more than two weeks, the State Board of Health does not recommend or furnish antitoxin for prophylactic use.

The Schick reaction is purely a local one, and the amount of toxin per cc. of the T-A mixture is so small that reactions following its use are usually absent or very mild. To secure the maximum benefit from the therapeutic dose of antitoxin, it should be given at the earliest possible moment. Ten thousand units should be the minimum dose, except in very small children or very mild cases.

Intramuscular injection gives much quicker relief than hypodermic, and the intravenous route produces results more promptly than either. In severe and advanced cases the intravenous injection is certainly to be given preference. Last year there were 105 deaths in Florida from diphtheria; undoubtedly some of them could have been prevented had the antitoxin been injected directly into the blood stream. Certainly it is the duty of every physician to stress the importance of immediate medical attention for every child with a sore throat. In all suspicious cases the immediate use of antitoxin, without waiting for a laboratory report, is recommended. The report from the laboratory is of great value as a guide to the care of the patient; it determines the measures for protecting other members of the family and community, and the time for terminating the period of isolation.

TYPHOID.

Nothing in this article is intended to undervalue the sanitary measures that have proven so effective in the control of communicable diseases. Every physician should be an educator—should keep his people so well informed and so deeply interested in health and sanitary measures that filth-borne diseases cannot spread in his community. There are many communities in Florida where the doctor's influence for health is readily perceptible, and it is pleasing indeed to the health officer to observe that certain doctors do not usually have secondary cases of typhoid, diphtheria or smallpox in families where they are called early to treat primary cases of these diseases. It is a simple matter to give definite instruction for the disposal of typhoid stools, but the resultant saving to humanity is incalculable and the effect on one's conscience is considerable. A prominent place in the doctor's health program should be given to typhoid prophylaxis. The three injections of bacterin can safely be given to young children and even to infants. The resulting immunity varies in degree and duration. It lasts for at least one year and may last three or four years, the average being about two and one-half years.

The bacterin furnished by the State Board of Health is put up in individual packages, each containing three one cc. ampules, each ampule representing a dose. Bulk packages are also furnished to health officers for immunizing large groups. Of this the initial dose is one half cc.; the other doses 1 cc. each.

A choice is offered between the straight typhoid vaccine and the "Triple" which contains, in addition to B. typhosus, B. paratyphosus, A. and B. paratyphosus B. The former is less likely to produce a reaction and the use of the "Triple" is not deemed urgent since paratyphoid is neither so common nor dangerous as typhoid.

SMALLPOX.

A marked increase in the incidence of smallpox since December 1, 1925, has been noted. During this time there were reported 2,700 cases, most of which were fairly mild. Had the disease appeared in the virulent form seen last year in other states, not a remote possibility, the toll of human life would have been stupendous. Fresh vaccine virus can be had at all times from the Laboratory, State Board of Health, Jacksonville, in packages of one, five and ten capillaries. There is no reason why the medical profession of Florida should not adopt the practice of many well-known obstetricians and pediatricians and vaccinate their little charges during their first year—certainly no child should go to school unvaccinated. The writer much prefers to vaccinate on the arm, above the insertion of the deltoid. Leg vaccination is objectionable because it is difficult to protect. The puncture method described in the pamphlet that goes out with the vaccine has decided advantage over the scarification method. It is practically painless, the reaction is less severe and the resulting scar smaller. There is less likelihood of infection.

The use of celluloid shields and bunion plasters is objectionable because the former retains moisture and facilitates maceration while the latter is dangerous because they may introduce tetanus germs. Obviously if there is no "take" the attempt to vaccinate is not a success and no immunity is acquired. The immune reaction should be recognized. It appears in persons who have

been vaccinated or had smallpox, and consists of a papule which appears within 48 hours and subsides without forming a vesicle.

Children vaccinated in infancy should be revaccinated on entering school and again when about ten or twelve years of age. It is rare that a revaccination is accompanied by a severe reaction.

SCARLET FEVER.

Scarlet fever is neither as prevalent nor as severe in Florida as it is in the Northern States. Much careful work has been done on the Dick test and immunization with the toxin of scarlet fever streptococcus, but the extent to which they are applicable is still a matter for investigation and the State Board of Health does not feel that the time has come to recommend their general use. Dependence is accordingly placed on isolation for thirty days from the onset and longer if there is any abnormal discharge from the nose, throat or ears, or any suppurating glands.

OPPORTUNITIES FOR STUDY IN VIENNA*

A. K. Wilson, M.D.,
Jacksonville.

Vienna, or Wien, Austria, is a city of two million people. It was in the beginning a Celtic settlement. Favorably situated on the Danube and the spurs of the Alps and Carpathian mountains, its summers are pleasant, having about the same temperature as Asheville. The people are genteel, polite, and obliging, being of the type found in our university cities and capitals. Vienna has for many centuries prided itself on its universities and medical schools. For years nearly every nation has been represented in her student body and it has become necessary to pass certain restrictions to keep out medical matriculates of neighboring countries. At present there is enrolled about thirty undergraduate medical students from America. The postgraduate school is also attended by all nations, but Americans are in the majority.

As to the history of Vienna medicine, I will quote the introduction as given in the Blue Book of the A. M. A. of Vienna: "The University of Vienna, the second oldest German language university, was founded in 1365. The medical school, however, was founded a little later, the first records dating from the end of the 14th century.

"The Viennese School of Medicine soon after its inauguration began to attract attention, but only in the latter half of the 18th century had its fame spread beyond the confines of the land. This was due not only to the pioneer work of some of the brilliant men engaged in research, but also to the fact that at this time a clinic patterned after that of Leyden was erected. This was the direct result of the arrival, as a member of the Vienna faculty, of Gerard van Swieten of Holland. To him is due the credit for this new impetus. This new clinic, opened in 1754, was the cradle in which such famous men as Hean, Stoll, and Peter Frank were raised and grew to fame.

"In the year 1784 the clinic was moved to the Algemeines Krankenhaus (General Hospital) which immediately took the lead in medical research and soon led the world in medical instruction.

"In addition to internal medicine and surgery, in the early part of the 19th century, especial progress was being made in opthalmology by Boer and Jaeger, and at the same period Boer was laying the foundations on which were later to be built modern pediatrics and obstetrics. The result was that even at this early date physicians from all foreign lands were visiting the Viennese clinics in order to bring their knowledge up to the high standards developed here.

"About 1845 the Viennese Medical School again reached a high pinnacle in its world fame as the greatest medical center.

"As a result of the collaboration of two geniuses in two distinct branches of medicine—Rokitansky, the pathologist, and Skoda, the clinician—a complete revolution was wrought in the conception of disease processes and their clinical manifestation, and thus, logically, to their diagnosis. In this work these two pathfinders followed in principle the Paris School of Medicine, but soon forged far ahead of anything at that time achieved there. In this way was laid the foundation of the modern art of healing.

"The work of these two medical giants was soon known throughout the whole medical world. The result was that again the Vienna School of Medicine was the center towards which physicians, students and investigators from all quarters came hurrying to see and learn the newly devised means of diagnosis. The result of this newly aroused enthusiasm did not, however,

*Read at the meeting of Duval County Medical Society October 5, 1926.

stop there. It reacted in every branch of scientific investigation and the results of this rebirth of clinical observation were seen in many departments. At this time Hebra was doing his work, which was to lead to a total reformation in dermatology; surgery under Schuh took on a new aspect. In anatomy Hyrtle not only enlarged our knowledge of this important branch of medical studies, but was the forerunner in giving enthusiasm to the succeeding anatomists. The awakening of the knowledge of anatomy and pathology led to an increased interest in the normal physiological processes, and under Bruecke enormous advances were made in this important branch of learning.

"With the renewed interest in these basic studies, it was natural that the clinical enthusiasm of Skoda should not remain without effect on others. And so we see at this same period that genial clinician Oppolzer and the wonderful advances in eye diseases through the efforts of Arlt and Ed. Jaeger.

"Then followed another group of men also influenced by the work of their immediate predecessors. These carried the renown of the Vienna School still further. Among the leaders of these, to mention only a few, were Meynert, the brain anatomist, the world-famous surgeon, Billroth, and the justly acknowledged clinicians, Bamberg, Nothnagel and Neusser.

"In Vienna, in 1847, an operation under ether anæsthesia was performed, and in the same year Semmelweis discovered the causation of puerperal sepsis. (Ed. Note: Oliver Wendell Holmes in 1843 wrote his paper on 'The Contagiousness of Puerperal Fever,' in which he showed the origin of this condition, and laid down rules for its prevention, all of which were later verified and amplified by Semmelweis).

"The widespread influence of Rokitansky and Skoda is responsible for the development of specialization in medicine, viz: Laryngology under the leadership of Tuerck and Czermak, the latter devising in 1857 the first laryngeal mirror; otology under Politizer, electro-therapy, hydro-therapy, etc. All of these factors leading still more to the estimation with which Vienna was held as a teaching center and showing itself in an increasing influx of foreign physicians for the purpose of further pursuing their studies here. This still continues and we see the further development in this specialization in urology, roentgenology and electrocardiology, etc., reaching a high plane of achievement.

"These founders of the Vienna School of Medicine have been followed by men in whose keeping the best traditions of the past are held sacred, so that today the same searching for new methods and new means is still an integral part of the routine of the faculty. It is therefore not to wonder that Vienna is still the city towards which all medical men—young and old—come to renew their knowledge and learn new methods."

For the convenience of visiting English-speaking physicians, a club was formed in 1903, called the A. M. A. of Vienna. The quarters of this association are in connection with a well-kept cafe, and situated across the street from the largest general hospital in Vienna, the Krankenhaus of 2,359 beds. This hospital, occupying about twelve blocks, is a city of itself. The general construction is that of an old Spanish mission with many cross segments intervening. This structure houses a number of hospitals, clinics, chapels, morgues, histological and pathological institutions, coffin-factories, etc. There are other hospitals in the city with a total of 12,879 beds.

The professors are hard workers and good teachers. The average professor and instructor spent many years of full time in the clinics. Some, prior to this, had months or years in a histological or pathological institution. The heads of departments are most exacting of their staff. They give the indications for operations and the kind to be done. The instructors speak fairly good English and are better understood by Americans than the Englishmen are. They make every effort to secure the best of clinical material. For example, Dr. Hajek had a patient come 150 miles to show the class a case of complete laryngectomy for cancer. Seven years had elapsed since the operation, with no recurrence, and the patient could speak clearly enough to be understood.

Patients are kindly treated and great consideration is given them.

Autopsies are done on nearly all cases that die in the Krankenhaus. Permission from the relatives is required, but as the physicians have the cooperation of the undertakers it is possible to do autopsies on all cases if desired. Great care is observed in not destroying the features of the corpse.

The courses vary in length from four to twenty hours. The instructor charges so much per hour, usually four to six dollars. The number of men to each class is limited. The larger the number the cheaper, as the charge per hour is divided by the number in the course. Some classes are limited to one or two as in bronchoscopy on the living and operation on the cadaver. The cadavers are fresh and usually are plentiful. The clinics for teaching are open every month in the year. August, however, is not so favorable as it is customary for the teachers to take their vacation at this time. These courses consist of advanced work and are better suited to those who have had previous training. In these clinics it is very demonstrable that it is of advantage to teach in a language which is not understood by the patient. The teachers here of the same class as are found in Vienna are steadily employed and cannot afford to take chances of getting a class now and then. In America the cadaver supply is a great question as sufficient bodies are difficult to obtain.

The boat trip going over to Europe gives ample time for the physician to relax from his strenuous practice at home and on the way back, from his work in Vienna. The doctor's family is kept busy visiting museums, castles, cathedrals and many places of historical interest.

My impression of European medicine is that preventive medicine is not considered of as great importance as in the United States. For instance, the Viennese indication for tonsilectomy is frequent attacks of tonsilitis, quinsy, endocarditis following an attack of tonsilitis, or the appearance of a disease due to infected tonsils. The tonsils being a focii of infection, from which some secondary infection might occur, or as a potential factor producing a disease as endocarditis is not considered an indication for tonsilectomy. They say there is time enough to remove the tonsils after a complication has developed. Focal infections are greatly ignored or neglected unless some discomfort is given the patient or a complication has developed. In this way the Viennese physicians are conservative. It is probable that the poverty of Europe has delayed the progress of preventive medicine.

I believe preventive medicine in America today is receiving far more attention than curative or restorative medicine. This science has been advanced not only to the prenatal but to the preconceptive periods of life.

NOTICE!

Fifty-Fourth Annual Meeting

of the

Florida Medical Association

will be held at

West Palm Beach,

April 5 and 6, 1927

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MEMBERSHIP

The membership of the Florida Medical Association at the time of the publication of this issue of the Journal is 1,088 as compared with a total of 804 for the same period during the previous year. The total number of our members having paid dues to the last of October this year is 996 as compared with a total of 667 for the same period for the previous year.

The officers of the Association during the past year have been most active in increasing the membership and at all times have had the hearty cooperation of the local county societies. The present administration is, indeed, proud of the record achieved in bringing the membership to such a number. It is hoped that we may see the mark at 1,200 before our next annual meeting.

SOME FACTS CONCERNING CANCER

On September 20 to 24, 1926, there took place at Lake Mohonk, New York, an international meeting on cancer control. The digest of the

conclusions reached concerning cancer are most illuminating and are particularly interesting to all practitioners of medicine. For that reason, we are giving herewith the report of this meeting:

STATEMENT OF THE FACTS AND OPINIONS AGREED TO BY THE INTERNATIONAL MEETING ON CANCER CONTROL HELD AT LAKE MOHONK, N. Y., U. S. A., SEPTEMBER 20-24, 1926.

Although the present state of knowledge of cancer is not sufficient to permit of the formulation of such procedures for the suppression of this malady as have been successfully employed for the control of infectious diseases, there is enough well-established fact and sound-working opinion concerning the prevention, diagnosis and treatment of cancer to save many lives, if this information is carried properly into effect.

1. The causation of cancer is not completely understood, but it may be accepted that for all practical purposes cancer is not to be looked upon as contagious or infectious.

2. Cancer itself is not hereditary, although a certain predisposition or susceptibility to cancer is apparently transmissible through inheritance. This does not signify that, because one's parent or parents or other members of the family have suffered from cancer, cancer will necessarily appear in other persons of the same or succeeding generations.

3. The control of cancer, so far as this subject can be understood at the present time, depends upon the employment of measures of personal hygiene and certain preventive and curative measures, the success of which depends upon the intelligent cooperation of the patient and physician.

4. Persons who have cancer must apply to competent physicians at a sufficiently early stage in the disease, in order to have a fair chance of cure. This applies to all forms of cancer. In some forms early treatment affords the only possibility of cure.

5. Cancer in some parts of the body can be discovered in a very early stage, and if these cases are treated properly the prospect for a permanent cure is good.

6. The cure of cancer depends upon discovering the growth before it has done irreparable injury to a vital part of the body and before it has spread to other parts. Therefore, efforts should be made to improve the methods of diagnosis in these various locations and the treatment of the cancers so discovered.

7. The public must be taught the earliest danger signals of cancer which can be recognized by persons without a special knowledge of the subject, and induced to seek competent medical attention when any of these indications are believed to be present.

8. Practitioners of medicine must keep abreast of the latest advances in the knowledge of cancer in order to diagnose as many as possible of the cases of cancer which come to them.

9. Surgeons and radiologists must make constant progress in the refined methods of technic which are necessary for the diagnosis and proper treatment not only of ordinary cases but of the more obscure and difficult ones.

10. There is much that medical men can do in the prevention of cancer, in the detection of early cases, in the referring of patients to institutions and physicians who can make the proper diagnosis and apply proper treatment, when the physicians themselves are unable to accomplish these results. The more efficient the family doctor is, the more ready he is to share responsibility with a specialist.

11. Dentists can help in the control of cancer by informing themselves about the advances in the knowledge of the causes of cancer, especially with relation to the irritations produced by imperfect teeth and improperly fitting dental plates. They can also help by referring cases of cancer which they discover to physicians skilled in the treatment of cancer in this location. It may be doubted whether all dentists fully realize the help which can be obtained from X-ray photographs in revealing not only the state of the teeth but the condition of the bone surrounding them.

12. Medical students should be instructed in cancer by the aid of actual demonstrations of cancer patients and this to a sufficient extent to give them a good working knowledge of the subject.

13. The most reliable forms of treatment, and, in fact, the only ones thus far justified by experience and observation, depend upon surgery, radium and X-rays.

14. Emphasis should be placed upon the value of the dissemination of the definite, useful and practical knowledge about cancer, and this knowledge should not be confused nor hidden by what is merely theoretical and experimental.

15. Efforts toward the control of cancer should be made in two principal directions: (1) the promotion of research in order to increase the existing knowledge of the subject, and (2) the practical employment of the information which is at hand. Even with our present knowledge many lives could be saved which are sacrificed by unnecessary delay.

THE NEXT ANNUAL MEETING

The Executive Committee has selected April 5 and 6, 1927, as the dates for our next annual meeting which is to be held in West Palm Beach. For several years past the annual meeting has been held in May, but owing to the request of the committee on arrangements in West Palm Beach, the date has been advanced. The local committee felt that holding the meeting in April would assure the members of the Association better hotel accommodations.

The Committee on Scientific Program has already addressed a letter to all members asking them to forward without delay requests for a place on the program. The committee is endeavoring to prepare the best program the Association has ever had. If you desire a place on the program, make your request without delay, forwarding same with title of paper, twenty-word abstract and the names of three doctors whom you wish to discuss your paper, to Dr. Stewart G. Thompson, Business Manager, P. O. Box 135, Jacksonville.

MEDICAL CONFERENCE

A medical conference has been arranged by Dr. H. Mason Smith, president of the Florida Medical Association, to be held February 8th. At this meeting, representatives of the State Board of Health, the State Board of Medical Examiners, the Florida Medical Association and councilors from all districts, together with the regular standing committees, will be in attendance.

STATE NEWS ITEMS

The Pinellas County Medical Society held its annual election of officers at the October 1st meeting and the following physicians were elected to serve until the first meeting in October, 1927:

Dr. L. A. Wylie, St. Petersburg, President.

Dr. H. L. Putnam, St. Petersburg, 1st Vice-President.

Dr. H. W. Wade, St. Petersburg, 2nd Vice-President.

Dr. O. O. Feaster, St. Petersburg, Secretary.

Dr. Emil Lustig, St. Petersburg, Treasurer.

Dr. R. H. Knowlton, St. Petersburg, Censor, three years.

Eight new members were admitted into the society at this meeting, six coming by transfer from the states of North Carolina, Georgia, Iowa, Pennsylvania, Indiana and Kentucky, and two by application. Pinellas County Medical Society now boasts a membership of seventy-eight "live-wire" physicians.

The many friends of Dr. J. R. Bean will be shocked to learn that he died October 27, 1926, at the Walter Reed Hospital, Washington, D. C., following an operation for tumor of the brain. Dr. Bean was thirty-seven years old. He graduated in medicine from the University of Pennsylvania in 1911 and has been very active in public health work during his professional career, having served as Director of Laboratories of Florida State Board of Health from October 1, 1925, until his recent illness incapacitated him for duty. His untimely death is indeed a great loss to the medical profession of Florida.

The De Land unit sent to the hurricane district, consisting of one surgeon, one operating room nurse, one anesthetist and five hospital orderlies, has returned home. They were in service first at the Jackson Memorial Hospital, then at the Fleetwood Hotel, Miami Beach, and later in sanitary work in the vicinity of Hollywood.

* * *

Dr. J. H. Pittman has returned to West Palm Beach after a vacation at Saluda, N. C.

* * *

Dr. N. L. Spengler of Tampa has returned from a month of pleasant motoring in the mountains of north Georgia, North Carolina, Virginia and Tennessee.

* * *

Dr. and Mrs. L. Lambdin of St. Petersburg are back from a pleasant vacation spent in Tennessee.

* * *

Lake County Medical Society invited Sumter County Medical Society to attend its meeting November 8th at Tavares. Dinner and speak-

ing. Dr. J. S. McEwan of Orlando was the principal speaker of the evening.

* * *

The Palm Beach County Medical Society did considerable relief work during the storm at Hollywood and Ft. Lauderdale.

* * *

Dr. John R. Boling and Dr. L. W. Blake of Bradenton left the first of October for a month at the Mayo clinic. They went by the way of Philadelphia to visit the Sesqui-Centennial and attend the convention of the American Legion.

* * *

Dr. Luther Holloway of Jacksonville addressed the Alachua County Medical Society at a recent meeting.

* * *

The many friends of Dr. Hiram A. Byrd of Bradenton will regret to learn of the death of Mrs. Byrd which occurred October 14th.

* * *

Dr. J. S. McEwan of Orlando spent the month of September in Cleveland, Chicago and Rochester, Minnesota.

* * *

Dr. H. Mason Smith, president of the Florida Medical Association, addressed the Dade County Medical Society in special session, 8:30 p. m., October 8th. Dr. Smith's address on organized medicine was to the point and full of good thought. The appreciation of the doctors present was expressed in a rising vote of thanks to Dr. Smith. The signs of the hurricane are passing so rapidly that within the next six months it will be ancient history even to Miamians.

* * *

Dr. and Mrs. H. W. Wade of St. Petersburg have returned to the city after a vacation spent in Canada and the Adirondacks.

* * *

Married October 19th, William Hill McCaslan, Tampa, Fla., to Miss Marguerite Cope of Union Springs, Ala.

* * *

Dr. and Mrs. Kenneth A. Morris of Jacksonville have just returned from a trip to North Carolina.

* * *

Dr. R. L. Hughes of Bartow recently resigned as county physician and manager of the Polk County Hospital and upon his recommendation Dr. J. L. Hargrove was named by the Board of County Commissioners to fill the vacancy.

* * *

Dr. F. Clifton Moor of Tallahassee spent the months of August and September at the Mayo clinic.

* * *

Omitted from the list of accredited hospitals published in the September Journal was that of the Christine Roof Memorial Hospital of Bradenton, Fla. This consists of twenty-five beds and was opened January 12, 1926, under the direction of Dr. John R. Boling who is surgeon in charge. This hospital is endeavoring to meet the requirements of the American College of Surgeons and will undoubtedly be classified as an "A" hospital in their next annual report.

* * *

Dr. A. F. Quillian of Bradenton is spending a few weeks in Atlanta, Georgia.

* * *

Dr. J. S. McEwan addressed the DeSoto-Hardee-Highlands County Medical Society at its meeting in Arcadia October 12th, using "Chronic Cholecystitis" as his subject.

* * *

The State Board of Medical Examiners held its semi-annual meeting at Tallahassee October 12th and 13th. The board consists of Doctors E. G. Peek, Ocala; John M. Mann, Lake Butler; J. E. Crump, Winter Haven; J. B. Griffin, St. Augustine; N. A. Baltzell, Marianna; S. G. Hollingsworth, Bradenton; J. D. Robinson, St. Petersburg; T. G. Vassar, Lakeland; S. E. Driskell, Jacksonville; W. M. Rowlett, Tampa, secretary, and Attorney A. T. Stewart of Tampa. There were seventy-three applicants.

* * *

Dr. J. Kent Johnston of Tallahassee spent several days in Atlanta during the past month where he attended the Georgia state rifle shoot.

* * *

Dr. E. L. Biggs of Starke has been recently appointed city health officer of that city.

* * *

Dr. Ralph Greene and Harold Van Schaick recently attended a meeting of the Second District Georgia Medical Society in Thomasville.

* * *

The marriage of Miss Dora Bonacker and Dr. John S. Helms of Tampa took place in Johnstown, Pa., recently.

The construction of a medical arts building of ten stories is contemplated in Jacksonville. This building will be complete in every detail for furnishing up-to-date facilities for physicians and dentists. The entire project will entail an expenditure of about $600,000.00. The building project is in the hands of a syndicate.

* * *

Dr. G. H. Edwards of Orlando spent the month of October in Baltimore, Philadelphia and Boston.

* * *

Dr. J. L. Boone of Jacksonville is spending some weeks in the North attending clinics.

* * *

Recently, Dr. Paul C. Ronning of Lake Worth, Dr. J. G. Heitz of Orlando, and Dr. Joseph D'Gratini of Tampa were placed in the custody of Federal authorities suspected of being connected with a fake license ring which was brought to light through the efforts of state and government operatives.

* * *

The Halifax district hospital commission recently awarded the contract for the building of the Halifax Public Hospital at Daytona Beach. The contract calls for the completion of the hospital by November, 1927, and the work is to start at once. The hospital is to cost something over $5,000,000 and will be one of the most modern in the state.

* * *

Drs. F. J. Waas and Herman H. Harris of Jacksonville read papers at a recent meeting of the St. Johns County Medical Society held at St. Augustine.

* * *

Quite a number of St. Petersburg doctors responded to an appeal for physicians from the east coast following the storm. Dr. O. O. Feaster, with a portable X-ray outfit, went on one of the relief trains with Drs. L. M. and N. W. Gable, Dr. N. M. Marr, Dr. S. B. Beiker, Dr. S. H. Townsend and several nurses. A ship loaded with medical supplies was sent out to Moore Haven with Drs. E. J. Melville, H. H. Cooke, and J. W. McLean. Later a second train was sent to Miami with Drs. A. P. Roope, R. N. Knowlton, A. J. Wood and H. R. Sackett. All doctors report a very busy time while there.

The Journal has been successful in obtaining a revised reprint price list which considerably reduces the cost of obtaining reprints. When reprints are desired after an article appears in the Journal, the writer is expected to forward a check in favor of the Record Company, without delay, covering the number of reprints desired. The printer maintains the type set-up until the 20th of the month following the issue in which the article appears. After that time any reprints obtained will cost considerably more than the following price list indicates:

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500	4.85	7.40	13.25	18.90	22.25
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1,000	34.20	38.50	46.95	12.10
1,000s Add.	17.60	22.10	24.30	10.85

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Number Copies.	2 pages.	4 pages.	8 pages.	12 pages.	16 pages.	Covers Add.
100	$ 4.30	$ 8.10	$13.90	$18.00	$19.05	$ 5.45
250	4.75	9.00	15.40	20.00	21.15	6.05
500	6.45	10.25	19.50	24.30	26.40	8.95
1,000	7.60	12.25	25.50	32.80	36.95	15.85
2,000	11.95	20.80	38.50	49.75	56.65	29.90
1,000s Add.	3.85	6.85	12.10	19.50	20.00	14.40

October 1, 1926.

Prices subject to change without notice.

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Dr. and Mrs. F. J. Waas of Jacksonville recently visited New York where they met their daughter on her return from a trip abroad.

* * *

The members of the Florida State Board of Health, composed of the President, Hon. Chas. H. Mann of Jacksonville, Drs. H. Mason Smith of Tampa, President of the Florida State Medical Association, and W. D. Nobles of Pensacola, met with the Broward County Medical Society at Fort Lauderdale, on the evening of October 7th. The members of the Board of Health were on a tour of inspection of the section of the state recently devastated by the storm, and were invited by the Society to attend their regular meeting. The meeting was presided over by Dr. Leslie H. Maxwell, President of the Broward County Medical Society.

Interesting addresses were delivered by Presidents Mann and Smith, Col. Percy L. Jones of

the Medical Corps, U. S. Army, and Dr. Wm. J. Buck of West Palm Beach.

President Mann spoke at length relative to the cooperation of the State Board of Health with the local authorities of the different cities within the storm section, following the recent destruction in this area. He stated that the Board's ability to have been of further service was hampered by the fact that the appropriations made by the Legislature were insufficient for the requirements of the State Health Department, but that the services of the Department were freely offered to the stricken district, to be used as the local authorities might direct.

President Smith's address was along the lines of the importance of organized medicine, and the necessity for combatting the advent of State Medicine. He pointed out the degradation of the profession, where State Medicine was in the ascendency, and the dire financial straits to which they were necessarily reduced by the inadequacy of the fees for professional services in the countries where this system had been permitted to gain control. He dwelt upon the fact that new County Societies were being organized throughout the State, and that the membership in the State Association was now around eleven hundred. He pictured the glorious future in this State for the profession if they would stand together in their County and State Societies, and would interest themselves in seeing that representatives were sent to the Legislature who would enact laws which would be compatible with ethical medicine.

Colonel Jones, who is stationed at Atlanta, Georgia, spoke of his work here, and emphasized the fact that the services of the Medical Corps of the U. S. Army were always placed at the disposal of the local civil authorities, in time of any great disaster, and that in all the years of his service in this and in foreign countries, in many ways, he had never before seen such widespread destruction. The Colonel stated that his work had brought him in close contact with the physicians of Broward County, and that they had, at all times, extended him every courtesy, and had cooperated with him in every way. He further stated that to know the physicians of Broward County was to admire them, and that he had never before come in contact with men, who, having lost their all, had arisen to meet adversity more bravely than they.

Dr. Buck, speaking for the Palm Beach doctors present, assured the physicians of Broward County that none could sympathize with them more deeply than the profession of Palm Beach County, as they were sister counties, and that within an hour after learning of Broward's calamity, the whole medical fraternity of Palm Beach County was on its way to offer their aid. He stated that Palm Beach County at all times stood ready to be of service to Broward County, in any way that she might be permitted to serve, and that none could have more admiration for her than her sister county had for the brave manner in which she had conducted herself throughout her recent affliction.

The Broward County Medical Society is a recently organized Society, but it is destined to become one of the most active within the State Association, as its personnel is unsurpassed. Its membership at present is twenty, but there are quite a few applications pending, which will receive favorable action.

There were about fifty present at the meeting, among whom were nine members of the Palm Beach County Medical Society, as visitors, viz: Drs. R. C. Dennison, B. F. Smart and F. L. Tatom of Lake Worth; Wm. J. Buck, R. H. Baldwin, John E. Hall, T. H. Odeneal, L. J. Netto and W. Y. Sayad of West Palm Beach.

* * *

Hope Haven is a preventorium and convalescent home for crippled children, located on Riverside Drive, Panama Park, in Jacksonville. It is run by the Tuberculosis Association of Duval County and was made possible by the Lions' Club of Jacksonville, for the indigent children of Duval County and the State of Florida; however, children of parents who are able to pay a small sum are not refused as in many instances it is not possible to have the proper treatment carried out in the home.

Hope Haven is big and roomy with large airy wards, sunny porches, spacious grounds with sunshine a-plenty, but with stately old trees to cast their shadows for play spots in the summer time. It is situated on the water and the big boats passing up and down the river are seen by the children daily. Here good food, rest, sunshine and careful nursing bring back health and vigor to the frail bodies so long accustomed to pain. Heliotherapy is being used in all of the orthopedic cases and good results are being obtained.

For many years Florida's lack of hospitaliza-

tion has been one of the greatest trials of the medical profession. Particularly was this true in the case of children who were suffering from illnesses where a long period of convalescence was necessary. According to good authority the State contained approximately 1,700 crippled children, many of whom were crippled because of tuberculosis. The general hospitals, though willing, and glad, to do their best, were not adequately equipped for the care of these children through the many months of convalescence. Hope Haven was built to meet at least part of this need.

Interested primarily in tuberculosis, and secondarily in other diseases as they relate to tuberculosis, first choice is given to tuberculosis orthopedic cases. Contact cases of tuberculosis, suspects, children much underweight, undernourished, or anæmic, are also eligible for admittance. Hope Haven is for white boys and girls of any denomination or nationality between two and twelve years of age. Preference is given to children of Duval County because it is from this population that the funds for running this institution are received. Children from other parts of the State are gladly accepted whenever possible.

Hope Haven has a full staff of specialists from Jacksonville, who give their time and services to the institution. Mrs. Agnes R. Gay is superintendent and has on her staff two graduate nurses and three trained attendants, together with the necessary culinary assistance and yard man.

For financial reasons it is impossible to care for children under two years of age, children who are incurable, or children who are mentally impaired. Active cases of pulmonary tuberculosis are not accepted. Cases demanding surgical treatment or those acutely ill are generally transferred to some of the local hospitals.

Applications for the institution should be made to Miss Mae McCormick, secretary of the Tuberculosis Association of Duval County, 520 Dyal-Upchurch Bldg., Jacksonville, Fla.

* * *

Through the courtesy of Dr. B. L. Arms and Dr. R. H. McGinnis of Jacksonville, thirteen issues of the Journal which were missing from the files of the Florida Medical Association have been supplied. At the present time the editor's office still lacks the following numbers, and as an endeavor is being made to build a complete set of Journals for the library of the Association, it is hoped that these missing issues may be received from the membership:

1914—All issues.
1915—All issues.
1916—All issues.
1917—All issues.
1918—March.
1919—March, April, June, August, September, November, December.
1920—January, February, May.
1921—March, June, October.

* * *

Dr. Ralph D. Murphy of St. Petersburg returned recently from a three-months stay in Edinburgh, where he has been doing nose and throat work.

* * *

Dr. W. C. McConnell, formerly internist at the State Hospital, Chattahoochee, is opening offices in St. Petersburg for the practice of medicine. Dr. McConnell's membership has been transferred from the Second District County Medical Society to the Pinellas County Medical Society.

ADVERTISERS' NOTES

INHALANTS.

The upper respiratory tract is armed by nature against bacterial invasion, but a little timely assistance when infection is just gaining a foothold is sometimes needed. The medicament used should not be of such a nature as to denude the nasal or pharyngeal epithelium of its protective mucus; on the other hand, it should be of a tonic or slightly astringent character—something that will moderate the catarrhal condition and assist in opening up the congested sinuses, without risk of injury to the delicate tissues.

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In this connection the reader is referred to the advertisement of Adrenalin Inhalant in this issue.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

County Society	Secretary	MEETINGS				Dues Paid
		Date	Time	Place	Luncheon?	
Alachua	W. Lassiter, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	71%
Bay	J. M. Nixon, M.D., Panama City.					100%
Bradford	Seeber King, M.D., Lake Butler.					100%
Brevard	R. D. Ferguson, M.D., Titusville.	Varies		Varies		100%
Broward	Leigh F. Robinson, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Commerce	No.	100%
Columbia	L. J. Arnold, M.D., Lake City.	2nd Monday.				82%
Dade	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.	83%
Duval	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.	100%
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	68%
Four Counties	G. C. Hardie, M.D., Ft. Pierce.					67%
Hillsboro	B. W. Lowry, M.D., Tampa.	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.	90%
Jackson	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.	89%
Lake	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	93%
Manatee	J. M. Davis, M.D., Bradenton.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.	90%
Monroe	G. R. Plummer, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	95%
Palm Beach	W. O. Arnold, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Monterey Hotel	Yes.	100%
Pasco-Hernando	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.	86%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every other Friday	8:00 P.M.	Fla. Art School	No.	98%
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	89%
St. Johns	I. M. Hay, M.D., St. Augustine.	3rd Monday	8:30 P.M.	Varies	Yes.	90%
Sarasota	F. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Second District County Medical Society	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	88%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	86%
Taylor	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	78%
Tri-County	I. W. Chandler, M.D., Avon Park.		8:00 P.M.	Varies	No.	89%
Volusia	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton-Okaloosa	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	89%

NOTE—(Secretaries: Please submit information to complete the above schedule.)

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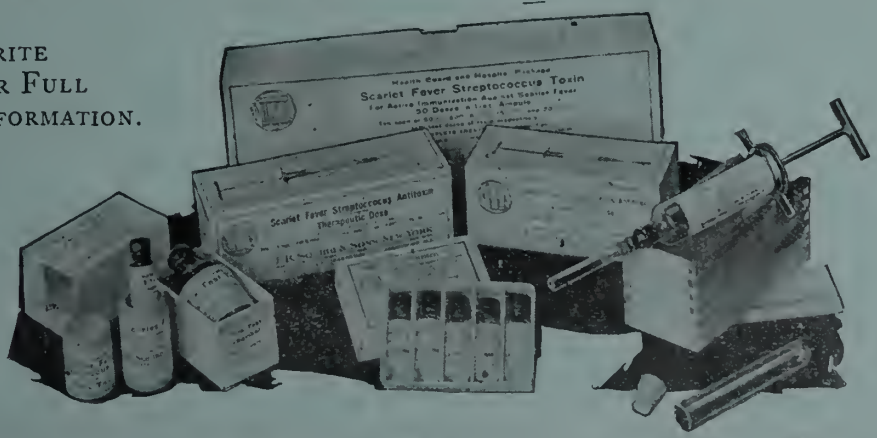
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CONTENTS

PAGE

The Estimation of Heart Reserve..... 126
Julian E. Gammon, M.D., Jacksonville.

Some Preoperative Factors Influencing the Mortality of Prostatectomy 130
John E. Hall, M.D., West Palm Beach.

Surgical Conditions Following Ureteral Strictures—Report of Cases..... 136
Edmund H. Teeter, M.D., F.A.C.S., Jacksonville.

PAGE

Anterior Poliomyelitis or Infantile Paralysis..... 140
F. L. Fort, M.D., Jacksonville.

Congenital Pyloric Stenosis 146
J. C. Davis, Jr., M.D., Quincy.

Editorial—Protection by Vaccination..... 149

State News Items..... 150

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THE ESTIMATION OF HEART RESERVE*

JULIAN E. GAMMON, M.D.,
Jacksonville.

Gentlemen: I want to discuss briefly the estimation of the heart reserve from a clinical and practical point of view. You know from practical experience that all of you with normal hearts have varying grades of heart reserve, that is, short or long winded, and you also know that after physical training an athlete's heart reserve is increased in accordance with the demands of his sphere of activity.

Exercise tests as a standard for judging heart reserve have not been satisfactory because of the marked variation in heart reserve in normal individuals. The sphere of activity within which the individual lives increases or diminishes heart reserve, as you have seen in the athlete. It is necessary, therefore, to keep in mind the individual's habitual sphere of activity, ascertain whether or not he has any circulatory embarrassment therein, in order to get a fair idea of an individual's response to effort.

You recall, no doubt, that during the war we had thousands of men who had apparently normal hearts as judged from physical examination. X-ray and electrocardiogram, but they were incapable of carrying on the strenuous physical and mental duties of the soldier. These men fell out of ranks with shortness of breath, precordial pain, tachycardia and fatigue under slight to moderate exertion. This condition was variously designated as effort syndrome, neuro-circulatory asthenia, neuro-circulatory myasthenia. The outstanding symptom of effort syndrome is marked fatigibility, not only of the circulatory system but of the neuro-muscular apparatus as well. To one who has examined large numbers of these men it is apparent that they belong to a substandard germ plasm. They can be easily classified into three groups: One, the physically inferior; two, the constitutionally inferior; three, psychoneuroses. Time does not permit further discussion of functional hearts.

Let us go further and investigate the organic heart and its reserve energy. Investigation of these cases usually includes careful history, physical examination and sometimes X-ray or electrocardiographic examination. By these methods we find definite evidence which indicates disease of the organ which necessarily means that the heart is handicapped in some degree, but our problem is to estimate how much the organic heart is handicapped. There are certain factors which I wish to discuss a little more fully which have a bearing on this question:

First, the age of the patient is important since young people repair damage more completely than old people whose hearts are undergoing degenerative processes. These degenerative processes may not be evident on examination.

Second, it is important to ascertain the etiological factor in the pathological process, since we know that certain diseases are progressive, others recurring and some are the fly-by-night type, that is, they cause their damage and disappear without recurrence.

Third, the time element or convalescing period is of importance because it is obvious that we can judge better the reserve of the heart after sufficient time has elapsed between the acute infectious disease and the period of retraining.

Fourth, the character of heart sounds is not of much value in estimating the reserve excepting during the acute illness marked diminution in the well-heard sounds may indicate muscle weakness.

Fifth, heart murmurs are of less importance than was formerly thought. Systolic murmurs require other evidence of disease before they can be given importance. Pressure blowing diastolic murmurs are usually indicative of heart disease.

Sixth, elevated blood pressure, especially high diastolic pressure, causes increased load on the heart and necessarily causes greater wear and tear on the heart muscle. Low blood pressure is not indicative of heart disease in itself; when associated with other evidence of heart disease it may be of importance.

Seventh, enlargement of the heart is always evidence of disease, and that the heart muscle is handicapped. The converse of this is not always true, as a normal size heart does not always mean

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

that the heart is normal. Many patients who die of the pain type of heart disease have little or no enlargement.

Eight, clinical disorders of the heart beat, with the exception of sinus arrhythmia, and some types of premature contraction, usually are evidence of serious heart disease.

Even though we have evidence of disease handicapping the heart, the degree of handicap can only be determined by seeing the heart perform within the patient's sphere of activity, and by the patient's ability to increase the heart reserve by retraining.

DISCUSSION.

Dr. M. J. Flipse, Miami:

The subject of cardiac reserve is a most difficult one to talk about because there is very little that can be stated definitely as to its measurement, and in this day of laboratory supremacy we are too apt to refer these cases to the laboratory man for exact measurement.

In regard to cardiac diagnosis: The electrocardiograph, the polygraph, blood pressure measurement, and X-ray have all been tried in an effort to arrive at a positive opinion as to the ability of a certain heart to do its work. In regard to the electrocardiograph, it gives us an accurate measurement of heart rhythm only and we may have a heart which has perfect rhythm but which is very imperfect in function. Blood pressure, as Dr. Gammon has said, does not give us a true idea as to cardiac reserve except in its interpretation with other factors which are present, such as history of the patient, previous diseases and their present activity. However, in regard to the blood pressure we may say this: Interpretation of blood pressure, diastolic and systolic, with careful attention as to the pulse pressure, may give us a very good indication as to cardiac reserve; provided, of course, that the aortic valve be intact. We then should have a relative percentage of diastolic pressure equal to a certain pulse pressure. With decrease in that pulse pressure it is our opinion that the heart muscle is dilated to a certain extent. In the presence of a diminution of pulse pressure with high diastolic, it is apparent that the heart muscle is unable to keep up the systolic pressure and then it gives us an indication as to the condition of the heart muscle.

As far as the polygraph is concerned, the same objections are open there as we cited in regard to the electrocardiograph. It shows rhythm and the relation of the various phases to one another rather than the condition of the heart muscle itself.

Dr. Gammon described heart reserve as functional efficiency. Personally, I cannot quite agree as to the definition. A heart may function perfectly for certain effort, but if the effort is increased it sometimes reaches a point where the heart is no longer able to function correctly, yet that individual may have a good heart reserve as far as his occupation requires.

I think in treating these patients we should first have a talk with them, let them understand that we must treat them over a long period of time if we are to build up their heart reserve. The explanation to the patient of what we can do for heart reserve is very important. A patient will come into your office complaining of some other condition, and you examine his heart and find that he has a low cardiac efficiency. You want to instruct him how to build it up. Concrete exercises and systematized rest constitute a most important regimen in building up heart reserve, and the patient must cooperate in order to get results. Therefore it is necessary to explain to the patient what you want him to do and why.

Regarding heart murmurs: Dr. Gammon stated that presystolic and diastolic murmurs always denoted an organic heart. I do not agree. We may find a diastolic murmur over the sternum in cases of cardiac dilatation, and we may find a typical pre-systolic murmur in the presence of normal heart valves. That was shown during the examination of a large number of army recruits. The functional test that we used put men through a certain amount of exercise and noted the return of the pulse to normal. I believe our present method is the best estimate of cardiac reserve. However, it is not a tape line that you can just measure and say you have so many points of heart reserve or you have so much ability to work. The history is of extreme importance. The occupation of the individual must be considered when we ask him what results he gets when he runs up a flight of steps.

In regard to the size of the heart: The large heart may have a hypertrophy sufficient to take up a condition of increased function and such patients have reserve, or the heart muscle may be weakened and still be enlarged. The acute cardiac dilatation instituted by a supreme effort I believe to be more amenable to treatment than those instituted by repeated effort over a long period of time. You can build up cardiac reserve

more readily in the case that has a dilated heart following a sudden strain.

In regard to the further work on cardiac reserve: You have the patient in bed and want to know when you can let him up. The best way to find out is to see what he does when he gets up. If the heart action increases rapidly and the pulse pressure remains low the indications are against letting him up again for some time. If the heart rate increases ten to fifteen beats to the minute and then comes back to normal when sitting in a chair, that patient should be allowed up at increasing intervals of time. It is better to give the patient too much rest and a prolonged period of recuperation rather than to try to hasten the case.

Dr. Herman Hirsch Harris, Jacksonville:

It has been a pleasure to hear Dr. Gammon's paper on cardiac reserve. I like to hear papers on this subject. After spending about seventeen years in intensive study of cardiac conditions, both in private practice and in some of the large cardiac clinics, I must admit that I do not know any too much about this subject.

There are so many factors which influence this matter of cardiac reserve, it becomes necessary to investigate as many of these factors as possible if we expect our results to approach accuracy. The history is in my opinion the most important factor in the examination, whether we approach the subject from the standpoint of cardiac physiology or cardiac pathology. The work that the patient is capable of performing day by day is after all the best test of cardiac efficiency. If a patient tells me that he is able to climb three or four flights of stairs, without becoming breathless or experiencing cardiac pain or distress, it matters little if I find his heart lacking in this or that, I must conclude that he has a good heart and I usually find by experience that I am right in this opinion.

The problem, however, is not always so easy. I am quite often asked to see a patient who is being prepared for operation. The surgeon has reason to believe that all is not well with his patient's heart. He wishes to determine if his patient is a good risk from a cardiac standpoint. As a rule the problem is not an easy one as no time is allowed for a long or repeated careful examination of the patient's circulatory system. Here again I believe the patient's history, as to previous rheumatic attacks, cardiac failures, breathlessness, palpitation, edema or cardiac pain, to be of first importance. The physical examination should be carefully made, especially with attention to cardiac enlargement and reaction to exercise, if possible, and much should be learned of this patient's myocardium and coronary circulation. Surely we should determine if the patient's heart is contracting in an orderly and efficient manner.

Seventeen or eighteen years ago about all we talked of was aortic or mitral regurgitation and stenosis, and that was about all we learned concerning hearts. But, nowadays, it's about the muscle and measurement of the heart, and how much time is required for each contraction. I think that in estimating cardiac reserve, we have two main factors to consider—what is the condition of this man's heart muscle, and what volume of blood is the heart throwing out into the system every time it contracts. When we purchase an automobile, if there is a forty horsepower engine in the car we are told that it will develop fifty horsepower if you put more gas to it and advance the spark. It is a pity we cannot say that about hearts—that they will develop so many foot pounds of work on a strain. But there is no simple way of measuring the amount of blood thrown into circulation at each cardiac contraction.

There are different exercise tests and some are extremely complicated. The Schneider cardiac efficiency test is quite a lengthy affair. The patient is tested as to pulse rate in prone position, and blood pressure in prone position; and then the blood pressure and pulse rate are taken in a standing position. If the pulse rate increases ten points, score one; and if it increases twenty points, score two. If the blood pressure rises 10 mm. we score him one or two, whatever the chart shows. After exercise, we give the number of increased beats per minute, and score so much for that. After waiting a minute or so for the heart to come back to normal, it is counted at one, two and five minutes, and these are averaged up and we give the patient a total score, for cardiac efficiency.

There are a great many of these tests from which you get a pretty fair idea of what the heart will do. I like this one best: When I have the patient in bed, I take the patient's blood pressure and pulse rate at rest, then ask him simply to raise the body or at least the upper part of the body to a sitting position ten times. I then take the blood pressure and pulse immediately after-

ward and again in one and two minutes. If the heart muscle is not efficient, you will find that the pulse will not slow down in one or one-half minutes, and there will be a delay in the rise of blood pressure. If normal, there will be an almost immediate rise in blood pressure. More blood will be thrown into circulation. But with diminished musculature, the pressure falls, or there is a delay in blood pressure rise.

Dr. Herbert Caldwell, Lake City:

I have been in government work for the past five or six years, and my work has been principally to try to estimate cardiac reserve in the patients who have come to these hospitals. I suppose in that time I have been asked to estimate this reserve at least fifteen thousand times. Perhaps that does not mean so much to us, but it may mean a good deal to the taxpayer when he remembers that the decision may make considerable difference to the treasury. Perhaps, not so much in each case, but when reported often enough it makes a great difference. And when you estimate that this is reported by a number of hospitals all over the country, the difference becomes enormous.

Now, I would like you to understand that when I speak of the patients in the government hospitals, of the Veterans' Bureau especially, I believe that the majority of them are honest. Most of them have either organic or nervous conditions which justify their presence in these hospitals. It remains for the doctors to estimate the amount of their disability, and whether or not this disability is connected with their service. Therefore we have to eliminate the very thing that Dr. Gammon told you to weigh, namely, the patient's own opinion of his heart disability. We are standing between the treasury on the one hand and the patient on the other. And this patient may tell you subconsciously whatever will advance his case. Therefore his opinion is practically worthless. That does not mean that we do not take into consideration his viewpoint. We consider it, but ninety-nine times out of one hundred he will trace the injury to something which occurred between seven and eight years ago, during service, and will give you answers which indicate that he is not able to perform labors that an ordinary individual does. All protest vigorously that they do not want anything from the government which is not theirs by right, but they would like to have that. The history of the case and his opinion of his inability to work are practically worthless. You have to get from that man what you can by making tests. His reaction to position, exercise, etc., is the evidence upon which you are to judge the case.

I have to disagree with Dr. Flipse on what he says about the polygraph and the electrocardiograph. While they are not the final word, they show a great many things beside just the variations of the rhythm. They sometimes show you weaknesses that would be unsuspected without the help of these instruments. I recall one case that we had in the hospital about a month ago with "Observation for myocarditis" on the chart. I put this patient through the regular routine examination of the heart which includes the pulse in three positions: after exertion, and two minutes later; the blood pressure before and after exertion. Apparently he responded to all of these tests well. He had a slight systolic murmur which was unimportant, and I would have said the man was normal, but there were the words, "Observation for myocarditis" on the chart. Perhaps some doctor who had developed a sixth sense—and many of them do—was able to diagnose that myocarditis. I asked for an electrocardiograph on this patient, which was taken on the same day, and showed this (demonstrating on blackboard): The P wave was too far ahead of the Q.R.S.; too long a pause between the auricular and ventricular contractions. The T wave was depressed. The man evidently either had myocarditis or had been taking digitalis. I found out he had been taking digitalis up to about three days previously. Two or three days later another electrocardiograph was taken and instead of showing the same condition, the P wave, his Q.R.S. and his T wave were apparently normal. Every few seconds he registered a long beat nearly twice the length of a normal beat, but the next was of ordinary length. He did not show the evidence of myorcarditis which he had shown on first examination. He did show sin-auricular block, that is, the impulse evidently started, but never even contracted the auricles. After the long pause there was a normal contraction again. All things considered, the patient evidently had a beginning myocardial weakness and a lessened cardiac reserve. I feel like Dr. Harris—after all of the evidence is collected it is difficult to tell the amount of heart reserve. And yet there is hope; the very fact of our willingness to concede the difficulties is a good sign and the work of many earnest men is bound to develop

gradually a surer method for the estimation of the vital point—cardiac reserve.

We should never overlook the fact that the polygraph and the electrocardiograph will show more than just irregularities of rhythm.

CONCLUSION.

Dr. Julian E. Gammon, Jacksonville:

In conclusion I want to point out that the sphere of activity in which an individual lives plays a large part in establishing a normal heart reserve; retraining, as in athletes, increases this reserve. Individuals in all walks of life with normal hearts have varying grades of heart reserve.

The functional heart, or so-called effort syndrome, is in reality not a heart disease. The individual belongs to an inferior germ plasm or sub-strata type. Fatigue, not only of the circulatory system but of the neuro-muscular apparatus, is the outstanding feature of this condition.

We know that organic disease of the heart causes various grades of impairment in its functional efficiency. This impairment can not be measured by physical examination, electrocardiograph and X-ray entirely, but must be measured by the patient's activity in his everyday life, free from symptoms of circulatory embarrassment, and his ability to retrain and increase his sphere of activity and necessarily his heart reserve.

I would like to illustrate this point by stating that I have records of a patient who had been a boiler-maker, served as a private in the engineers corps, completed his training in a training camp in the United States, went overseas, was in the pick and shovel fight at Kimmel Hill in which he was wounded in the leg by a bayonet. He was sent back to the base hospital for treatment and it was found that he had an irregular heart. He was later sent to Lakewood, New Jersey, to General Hospital No. 9, and there we found that he had a moderately enlarged heart with an auricular fibrillation. He stated he had had rheumatic fever a number of years before, that his family physician found his heart irregular five years previous to admission to the hospital. We found on electrocardiographic examination that he had auricular fibrillation. He had experienced no especial discomfort from his heart during his service or during the time that he was a boiler-maker.

I recall another man who had an enlarged heart with complete heart block, pulse 35 to the minute, and the electrocardiographic tracing showed that he had a complete heart block and auricular fibrillation. This young man had experienced no heart embarrassment whatsoever, and took pride in demonstrating his athletic ability. I could cite numbers of other patients to substantiate this point, but time does not permit.

SOME PRE-OPERATIVE FACTORS INFLUENCING THE MORTALITY OF PROSTATECTOMY*

JOHN E. HALL, M.D.,
West Palm Beach.

Symptomatic treatment of prostatic hypertrophy by the general practitioner is directly responsible for the high mortality of prostatectomy, and as a result of such treatment, thousands of old men afflicted with this disease die annually. This is a harsh but, nevertheless, true accusation, since he is the one to whom the prostatic first applies for relief in the initial stages of his disease, and if, at this time, he told the patient that surgical treatment was the only form offering him any hope of permanent relief, and advised that such treatment should not be deferred, many would live who otherwise die.

The general practitioner comes in contact with this disease more frequently than he does any other, in which surgery is so obviously indicated, yet in no other is he so prone to institute palliative treatment, regardless of symptoms. The reason for the institution of such treatment can not be attributed to lack of understanding on the physician's part as to the nature of the condition, for the subjective symptoms, together with the patient's age, render the diagnosis obvious.

Can he explain his attitude in the treatment of these patients? Is it because he thinks such treatment is really indicated, and is not aware that he is dealing with a mechanical obstruction which is amenable to surgical removal only, and that statistics show twenty per cent of all such cases degenerate into malignancy? No, the general practitioner is essentially well informed, and is fully cognizant of the underlying cause bringing about the subjective symptoms. His reluctance in advising surgical treatment may be ascribed to the fact that he recalls, without having to go far back into the past, that the mortality following this operation was so great it was universally thought arrangements should be made with an undertaker to conduct the coming

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

funeral, before the operation was performed.

In order to overcome this tendency toward operative procrastination on the part of the general practitioner, it is necessary to convince him that the following statements are true: First, that prostatectomy before the advent of kidney functional tests and blood chemistry determinations, and prostatectomy at the present time, are entirely different procedures, with an altogether different operative outcome. Second, that this operation is no more to be dreaded than an appendectomy, performed upon a patient of similar age, if done before serious secondary changes have taken place in the renal and cardiovascular systems.

He should be impressed with the fact that the constant presence of a residual urine, around two and one-half to three ounces, is sufficient to justify one in advising a prostatectomy. This amount is enough to cause more or less back-pressure on the kidneys, and it gradually increases as the gland enlarges, resulting in destruction of these organs by such back-pressure and infection. Self catheterization by the patient for relief of the residual urine should never be encouraged by the physician, on account of the possibility of resultant infection following its use. Watson compiled the outcome in 207 cases of prostatic obstruction, in which self catheterization was instituted. He states from these figures, that during the first month following institution of catheterization, the mortality was eight per cent, and in the first two months it was ten per cent. This form of treatment offers no hope of saving the patient from ultimate operation, which has to be performed under less favorable conditions than those existing before the initial catheter treatment.

Halle and Albarran denounce the use of the catheter as a palliative measure on the grounds that many cases of prostatic hypertrophy have a tendency to become malignant, and contend that since this is true, no treatment other than operative is justifiable in this condition. There is another reason why prostatectomy is looked at askance by both the laity and physicians. It is generally thought that prostatectomy not only destroys sexual function but also desire. This belief militates against early operation, as few men ever reach the age where they are willing to renounce all hope of sexual potency.

Is it true that prostatectomy produces this result? Let us see what the urologists have to say. At the meeting of the International Urological Congress in 1920, the consensus of opinion was, that following a properly performed supra-pubic prostatectomy, the genital function was not endangered, but to the contrary, many of them have an increase in sexual power following this operation.

That injury does not result is explained by Blum of Vienna, thus: "There is no such thing as prostatic hypertrophy, the real truth being that it is a neoplastic disease, or the formation of an adenoma of the submucous glands of the prostatic urethra, within the prostate. The prostate is shoved aside by the encroaching adenomatous growth, and is converted into a capsule, consisting of atrophic prostatic tissue, poor in glandular substance and surrounding the adenoma. This capsule, which is really only the atrophied prostate, contains the ejaculatory ducts, shoved aside and occluded by the surrounding pressure." He further states that following a correctly performed supra-pubic enucleation, there is no destruction of the seminal ducts, and instead of rendering the patient impotent, there is a rejuvenation after enucleation, due to the fact that following removal of the adenoma, a regeneration of the compressed and atrophied prostate takes place. As a result, it follows that the normal function, both excretory and incretory, is resumed.

Zuckerkandl and Cuthbert Wallace agree with Blum that the operation exerts no influence on the sexual powers, other than to cause an increase in sexual desire and potency, as health and strength are regained. Zukerkandl further states that a number of his patients had ejaculations after prostatectomy, and one of them had living spermatozoa in the ejaculated fluid.

Since the urologist is rarely referred any but the far advanced prostatic patient for operative treatment, it is not amiss to describe the typical one as he appears at this time. One sees an apathetic old man, morose and despondent, whose muscles have atrophied and withered away. His eyes are dull and vacant, with wrinkled pouches beneath them. His skin has a death-like cast, and is cold and clammy to touch. His arteries are hardened and distended. His breath has a characteristic urinary odor, and the tongue is dry, furred and thickened. His bladder is overdistended, and not infrequently he has an overflow dribbling. One realizes at a glance that he is dealing with an old worn-out human wreck, sick, weakened and poorly nourished from lack of food assimilation, exhausted by loss of sleep,

due to getting up at short intervals throughout the night to urinate; toxic, on account of blood absorption of poisonous retained products, and uroseptic, as a result of impairment of renal function.

As an operative risk, such a man is almost a negligible quantity. However, it is expected of us to operate and functionally restore him. It is to our credit that we take these worn-out old men and successfully operate upon them. By doing so, we not only relieve them of their constant suffering but give them comfort and add quite a few years to their lives.

Taking a patient as described, and getting him into condition to undergo this severe operation, with a reasonable degree of safety as to the operative outcome, entails much time and close observation on the urologist's part. Preoperative treatment may have to be continued for many weeks, or even months, in order to bring about such a result. Naturally, the first step is to empty the distended bladder and relieve the kidneys of the back-pressure exerted upon them. This in itself is a simple matter, but sometimes dire consequences follow when emptied too rapidly by catheterization, as one or both of two things may happen. The first is that severe hemorrhage may take place and immense clots form in the bladder. These clots can only be removed by cystotomy. Such hemorrhage is caused by the rapid release of the intra-vesical pressure on the distended veins of the bladder walls. The second is acute congestion of the kidneys with complete suppression of urine, in which case death may ensue. These two things happened to a patient of mine several years ago, since which time I have been exceedingly cautious in dealing with distended bladders. This applies following cystotomy in such cases. The rapid release of intra-renal pressure is followed by great dilatation of the renal blood vessels, and suppression of urine. For these reasons, the emptying of a distended bladder should extend over a period of time sufficient for the readjustment of the renal and cardio-vascular systems to the diminished pressure.

The next step following bladder decompression is to bring about both mental and physical reaction from the uremic or uroseptic state. The majority of advanced prostatic patients are listless, taking little or no interest in anything, and utterly hopeless as to their outcome. The prime essential in treating such patients is to inspire them with confidence in one's ability to render them assistance. It is necessary to constantly reassure them that they are improving and, following operation, will be restored to health. Unless one is able to overcome their fears and doubts, little can be done toward bringing about a physical reaction.

Water must be given them in large quantities to aid the excretory organs in throwing off the retained poisons. Many of these patients are unable to drink much water on account of distaste and nausea, and one is forced to administer fluids by proctoclysis, or hypodermoclysis. Normal salt solution may be used, but a five per cent solution of bicarbonate of soda is preferable, since it increases the alkaline reserve of the body and lessens the liability of acidosis. Nearly all of these old men are constipated, due to leading sedentary lives and, too, because the enlarged gland mechanically obstructs the normal passage in the rectum. Close attention, therefore, should be paid to keeping the intestinal tract flushed out with salines, as this greatly assists in the elimination of toxins.

Much discussion has taken place as to whether the bladder should be drained by the indwelling catheter, or the supra-pubic tube. Personally, drainage by means of the retained catheter is preferred, as this eliminates having to deal with scar-tissue around the supra-pubic wound at the time of enucleation of the prostate. However, in my hands, the catheter has not given satisfactory drainage for any considerable length of time. It not only has a frequent tendency to become occluded but also to slip out of the bladder into the urethra, regardless of how much adhesive tape is used to anchor it. Another objection to its use is that urethritis almost invariably develops within a few days following anchorage, with epididymitis as a subsequent result in quite a few cases. It is easily explained why epididymitis should follow the placing of the permanent catheter, when one recalls the anatomy of the urethra. The catheter mechanically irritates the entire urethra, causing inflammation, followed by infection. This infection involves the entire canal, and as the ejaculatory ducts open upon, or within the margins of the prostatic sinus, it is conveyed upward through them to the seminal vesicles and along the vasa to the epididymes.

As previously stated, about twenty per cent of all cases of prostatic obstruction are found to be malignant, and as the application of radium is indicated at the time of operation (conceding that such a gland should be enucleated), it is

imperative to ascertain, prior to operation, the presence or absence of this condition. Cystoscopy is valuable in determining this. Malignancy presents a picture of ulcerative areas, with hemorrhagic tendencies, nodular elevations and evidences of infiltrations, particularly if degenerative changes have taken place. However, many cases do not show mucosal involvement until in the latter stages of the disease. Cystoscopy should be employed as a routine in the examination of prostatic obstruction cases, if force does not have to be exerted in introducing the instrument, and the patient's general condition is good. There are quite a few cases in which the urethra is distorted and elongated as a result of the glandular hyperplasia, and this interferes with the passage of the cystoscope. However, the information gained from an intra-vesical picture fully justifies the bladder disturbance incident to the passage of the instrument.

The information furnished by the phthalein test and blood chemistry examination is of paramount importance in determining the renal function. The phthalein test indicates the excretory power of the kidney, while blood chemistry tells us the exact amount of waste products retained in the blood, which under normal conditions are eliminated.

Olmsted and Caulk claim there is a fairly constant relation between the excretion of phthalein and retained blood nitrogen, and they have seen no cases of nitrogen retention which showed normal phthalein excretion. They further state it is exceedingly rare to see nitrogen retention, unless the phthalein excretion is forty per cent or less, in two hours, and this is true in any type of low kidney function.

Columbet (Journal d' Urologie) claims the phthalein test is a better operative index than blood urea determination, stating that urea retention in the blood is in direct relation to alimentation, except when there are very advanced renal lesions, since the amount of blood urea may almost always be reduced to a safe operative point by proper regulation of diet. He believes an output of forty-five per cent phthalein in the first two hours, following intravenous injection, is sufficient indication for safe operative risk, and that this test is superior to all others, from the standpoint of prognosis in prostatectomy. Bransford Lewis, of St. Louis, on the other hand, believes the hemoglobin percentage is of greater value than the phthalein test as a factor in prognosis. He asserts a hemoglobin percentage of sixty per cent indicates a favorable outcome, fifty per cent is questionable, forty per cent unfavorable, and thirty per cent fatal following operation.

It should not be forgotten that the quantity as well as the specific gravity of the urine are important factors, as an increased output of persistently low specific gravity indicates the presence of a low grade interstitial nephritis.

Another preoperative, as well as postoperative factor influencing the prognosis, is the nursing of these patients. The average nurse knows nothing and cares less about nursing prostatic patients, and if she undertakes the care of such a case, it is because work is slack with her at the time. One doing this special line of operative work should have specially trained nurses to take care of his patients, or else he will lose many whom he should not lose. Such nurses should have cheerful dispositions, as well as tact and sympathy, as these qualities are essential in the management of old men who are, as a rule, babyish and exceedingly obstinate.

In closing, I desire to state there are other preoperative factors of importance, but time prevents taking them up in detail.

DISCUSSION.

Dr. E. S. Gilmer, Tampa:

I have enjoyed hearing Dr. Hall's paper on a subject that is of importance to both the general practitioner and the specialist. Prognosis is the most important phase of conditions of this kind. There are three systems in the human body that influence mainly the prognosis of prostatectomy, namely, respiratory system, urinary system and cardio-vascular system. Respiratory system is not as important now as formerly since we have begun the use of local and regional anesthesia. The urinary system is of considerable importance, although some of us will pay too much attention to this to the exclusion of the cardio-vascular system. In the urinary system we determine generally the condition of the kidneys by determination of renal function and by the blood chemistry. I think in the blood chemistry the amount of nitrogenous retention is not of so much importance as its stability, that is, its consistency. We can have considerable over the normal amount of nitrogenous retention, but if it is consistent we can safely do a prostatectomy in a great many cases. Kretschmer reports a case where the patient had as much as 9 mg. of creatinin to 100 c.c. of blood, but it was con-

sistent and his general condition was good. He operated and carried the patient through to a complete recovery. The condition of the cardio-vascular system also greatly influences the prognosis of prostatectomy. I do not think we should ever operate on a patient with a very high or a very low blood pressure. In every case before we operate the aid of a competent internist should be employed to determine the patient's general condition, particularly as regards to the cardio-vascular system.

Another factor influencing prognosis of the operations is the anesthetic. Before we began the use of local and regional anesthesia, we had a great many more deaths than we do now, due directly to a general anesthetic. Personally I like the sacral or caudal anesthesia. Have used spinal anesthesia several times, but have been frightened by it once or twice and am afraid to use it.

The mental attitude of your patient has much to do with his recovery. If the patient goes under operation depressed and with the impression that he is going to die, his chances are not nearly as good and he should be kept under observation until he is in a better frame of mind.

As to the preparation of the patient, whether the operation is done in one or two stages, I do not think this particularly influences the outcome of the ordinary case. To do a one-stage operation you must do your preliminary drainage by means of a retention catheter. In some cases you cannot pass a catheter through the urethra into the bladder and in others there is an intolerance to the presence of the catheter in the urethra, when you have to do a supra-pubic cystotomy which is more or less dangerous in cases of large amounts of residual urine.

As far as sexual results are concerned I believe that a prostatectomy should not necessarily incompacitate a patient. I recall two cases I operated on recently who state that they are better sexually now than before operation.

Before closing I wish to emphasize one point that Dr. Hall brought out, and that is about catheterizing and completely draining the bladder of those old men who have an acute retention of greater or less amounts of residual urine. This is a dangerous procedure and will often induce uremia and bring about the death of the patient.

Dr. Robt. McIver, Jacksonville:

The comprehensive paper on this subject and the full discussion that Dr. Gilmer has made, developed the salient points. I will indicate some data from the preoperative study of a consecutive series. Emphasis was made that these cases require, and it is necessary to give them, a most thorough examination, because we are dealing with individuals in the declining years of life, the majority being found in the decade between sixty-five and seventy-five.

Prostatics require team work more than any class of patients in need of surgical attention. By close cooperation between the surgeon, who should be a competent cystoscopist, the internist and the clinical laboratory, a material gain is assured.

In our series the additional diagnoses preponderate in the cardiovascular system. The arteriosclerotic group and the cardiac lesion group constituted about one-third of the additional diagnoses found; secondly, the pulmonary system, bronchiecstasis and bronchitis; and thirdly, nephritis and hypertension. One case of appendicitis developed acute retention and had to have the prostate out before he was able to leave the hospital.

Cystoscopy determines the presence or absence of foreign bodies, stones, tumors and diverticulæ. A large diverticula may contain stone, and here a cystogram gives definite data. It is well to rule out the possibility of tumor. Recently a case was sent in for hematuria. It developed that he had an enlarged prostate and the hematuria was attributed to engorgement of the veins of the vesicle neck. Cystoscopy showed a bleeding papilloma on the left wall of the bladder, so that there were two surgical conditions present. Cystoscopy also aids in selecting the type of operation to be performed.

In our series the majority were between sixty-five and seventy-five years. The oldest in the series was ninety, and there were several above eighty. The older patients seem to do almost as well, but their preparation usually requires a longer time.

The principal symptoms in this series were frequency, disuria and retention. The residual urine varied from 60 c.c. to 1600 c.c., with an average of 240 c.c. Preliminary treatment was entirely after supropubic drainage.

Before treatment, the best phthalein was 60%, the lowest 10%, and after preliminary treatment the best phthalein was 80%, the lowest 50%. In other words, before drainage the average case presented phthalein 38%, and after cystostomy, 65%. Blood urea: greatest retention 61 mg.

per 100 c.c. of whole oxalated blood, the lowest 20; averaging 35 mg. before and 18 mg. after treatment. Creatinine: the highest retention 7.1 mg. and the lowest 1.8 mg., averaging before 2½ mg. and after treatment 1 mg. The output of urine, another important point, on admission averaged 1200 c.c. in twenty-four hours, and after preliminary treatment, 2800 c.c.

Of the cases handled, 28 were general hypertrophy, 8 fibrosis, and 4 median bar. Suprapubic two-stage operation 36, and the cautery punch operation 4.

Of the forty cases there was no case of postoperative incontinence, and no case of postoperative fistula. There was one case of postoperative dysuria and one case of prolonged dribbling.

Before closing I would like to emphasize the importance of doing this work without the use of a general anesthetic. The choice of local infiltration, combined caudal and transacral block, or spinal anesthesia should rest with the surgeon. Caudal anesthesia combined with the sacral block gives satisfactory anesthesia in the big majority of cases. Of forty cases all done under transacral block with caudal injection, a general anesthetic was given to only one case. The anesthesia was poor in two, fair in two and satisfactory in thirty-five.

Dr. W. W. Kirk, Jacksonville:

This morning there was some very interesting discussion of heart reserve preliminary to operation. Granting that the prostatectomy case that is coming up for operation and the respiratory apparatus is in good condition and the heart is in as good condition as can be expected, still with the patients that average from sixty-five to seventy-five years of age, I think the surgeons will admit that they have a potentially serious risk.

I am going to take the liberty of first discussing this element of the blood nitrogen question in relation to the selection of the time of operation in this type of cases. We grant that the patient has had an adequate amount of urinalysis work and a sufficient study of the phthalein elimination. The normal blood urea nitrogen to the 100 c.c. of oxalated blood is 12 to 15 mm. of nitrogen, and it is quite constant on the average diet to which the patient is accustomed. Your prostatic case has probably been on a nephritic diet for some time in a number of instances, but a non-complicated case will probably not show much more than an average of 18 in simple hypertrophy. They show this average of 18 to 20 quite routinely in the absence of complications of note. These cases can be operated on provided the preparation mentioned previously has been done with a reasonable degree of success. On the other hand, there must be caution exercised when there is an average of from 20 to 25. It is safer to reduce them to a lower level, which can be done in the method which the doctor has outlined. Cases, on the other hand, which show a 25 plus or from 25 to 50 should not be operated on without every possible precaution.

The nitrogen determination can be made in one-half hour, and at very little additional expense to the patient, and I feel personally that every precaution should be taken in these cases regardless of what we might know about them, as the age factor alone makes them a potentially serious surgical undertaking.

Dr. Edmund H. Teeter, Jacksonville:

There is just one point that I would like to add. When in Philadelphia last October I saw Deaver, who was doing quite a number of prostatectomies. The mortality, he stated, in suprapubic prostatectomies was about twelve per cent in a certain hospital, which was entirely too high. In Baltimore, Young, using the perineal route, reports his mortality as low as three and one-half per cent.

In the latter operation there is one great advantage over the suprapubic prostatectomy, and that is your operative field is always exposed and you can definitely control all hemorrhage. Therefore, I feel that the perineal prostatectomy is the route to be chosen in the majority of cases.

Dr. C. D. Christ, Orlando:

Perineal prostatectomy as compared with suprapubic prostatectomy in the hands of the average general surgeon is not very good. Young has acknowledged that every man who has seen him work concedes that. There are a great many more dangers in the perineal prostatectomy and I rather doubt that the hemorrhage is so easily stopped, in that way. In the suprapubic prostatectomy where you can fully expose the bladder with the triple tractor, and where you can go down and suture the two edges together and absolutely stop all bleeding, it is by far the most satisfactory thing in the hands of the general surgeon. Now, in the results, some of the most favorable die on you, and some of the worst of the worst will get well. The clinical laboratory

findings are certainly most excellent and they are a guide where a man has that facility, and every man who is doing that work today should have at least the major portion of these facilities at his command.

After all is said and done about selecting your cases, when a case comes in to you with acute retention you must do something for him. You attempt to catheterize him but cannot do it. You can't get a soft rubber catheter in, nor a metal catheter by. You must give him relief, and the next thing to do is a preliminary suprapubic drainage. I do think that where the bladder is infected a two-stage operation should be resorted to. However, I do think that too many two-stage operations are done. In a lot of these cases with a limited degree of infection in the bladder, a one-stage operation can be done, the hemorrhage can be stopped and it saves the patient a great deal of time and a great deal of trouble, and I believe it lessens your mortality in lots of cases.

CONCLUSION.

Dr. John E. Hall, West Palm Beach:

I have nothing further to say, except that I desire to thank the gentlemen for their liberal discussion of my paper.

I refrained from taking up the perineal and suprapubic methods of operation, as that usually brings about an interminable discussion as to the relative advantages and disadvantages of each separate method.

It was stated by one of the gentlemen in his discussion of my paper that hemorrhage was more likely to follow the suprapubic method than it was the perineal. I beg to differ with him on that point. Following cystotomy, there is a shrinkage of the distended veins of the bladder walls and also of those of the capsule of the prostate, and after constant drainage by this method, the vascularity is diminished to a great extent, thereby lessening the danger of hemorrhage at the time of the second stage, or the enucleation of the gland.

As to the length of time that these patients should be drained before doing the second stage, this varies with the individual patient. I have allowed them to drain as long as eleven months, in one case, before the nitrogen was reduced to within safe operative limits. The specific gravity of the urine should be considered along with the blood-urea, as a persistently low specific gravity is an unfavorable preoperative factor.

SURGICAL CONDITIONS FOLLOWING URETERAL STRICTURES—REPORT OF CASES*

EDMUND H. TEETER, M.D., F.A.C.S.,
Jacksonville.

It is evident that we have been neglectful of the urinary tract for years and it is just in the past few years that we have realized the great importance of a thorough urological study. Pages are being added daily to our knowledge and technique of the kidney tract.

I will endeavor to report a few cases within the fifteen minutes that I am given for this paper.

I will divide my cases into two classes: (1) Conditions resulting from ureteral strictures with stone formation. (2) Conditions resulting from ureteral strictures without stone formation.

(1) Conditions resulting from ureteral strictures with stone formation. It is a fact that urologists realize that urinary calculi are caused by urinary stasis.

Case A: Patient, Mr. H. Referred by Dr. Stanley Erwin of Jacksonville. With the diagnosis of double nephrolithiasis. Entered St. Luke's Hospital on December 10, 1920.

Diagnosis: Double nephrolithiasis. Double ureteral stricture.

Family history: Negative.

Chief complaint: Weakness, lassitude and slight tenderness in right kidney region.

Past history: Negative, except patient passed blood in urine two years previous. Inflammation of bladder twenty-five years previous. Patient was weak and tired easily.

Cystoscopy on December 10, 1920. Pyelogram showed many stones in both kidneys. A differential phenolphthalein done and first hour right kidney excreted 35%. First hour left kidney excreted 5%.

Operation at St. Luke's Hospital on December 11, 1920. Usual lumbar incision made over left kidney. Left kidney delivered into incision and opened from one end to the other and forty-seven stones were removed. Patient had a good recovery and left hospital on January 1, 1921.

Cystoscopy on May 27, 1921, still shows some obstructions in both ureteral orifices as bulb was passed. A differential phenolphthalein was done intravenously, showing right kidney at end of first hour excreted 35%. Left kidney at end of

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first hour excreted 17½%. This shows a great increase in the excretion of left kidney since operation. General health very much improved.

Case B: Patient, Mr. B., age 57.

Family history: Negative.

Past history: Negative except operation five years previous. Removal of right ureteral stone.

Pyelogram shows a stone in right kidney pelvis. Cultures, left kidney and bladder negative. Guinea pig test was negative for tubercle bacilli.

Cystoscopy on March 2, 1925. Bladder wall was normal. Left ureteral orifice stands open and is irregular in outline. Intravenous phenolphthalein shows as follows: Left kidney first hour excreted 40%. Right kidney did not show a trace of phenolphthalein.

Patient entered hospital on March 10, 1925, with diagnosis of stone in right kidney pelvis with atrophy of right kidney.

Operation at St. Luke's Hospital on March 11, 1925. Right nephrectomy. Patient left hospital on March 26, 1925, in a good condition. General health has been good since operation.

Case C: Patient, Mrs. D., female. Age 30. Housewife.

Family history: Negative except father died of Bright's disease.

Diagnosis: Stone in left ureter one inch above the bladder.

Chief complaint. Eight years ago patient began having attacks of left kidney colic. Those attacks have returned several times each year. The attacks have gradually gotten worse for the last year. Attacks were accompanied with severe pain in left kidney, hip, nape of neck, headaches, and vomiting.

Past history: Negative except for headaches and spells of kidney colic. Patient has suffered with indigestion for past five years. Patient gives history of X-ray four years ago showing stone in left ureter. Patient had an operation in 1917. Appendectomy and right oophorectomy.

Cystoscopy on October 12, 1922. Many efforts failed to pass obstruction in left ureter, but a small bougie finally passed the obstructing point. Catheter could not be forced by obstruction.

Cystoscopy on November 22, 1922. Other efforts were made to pass obstruction in left ureter which was about one inch from vesicle orifice. A small bougie passed the obstructing point.

Patient entered hospital on December 15, 1922.

Cystoscopy on December 16, 1922. Efforts were made to get a catheter to pass the obstruction in left ureter and failed. A No. 9 renal catheter and 4 2/3 mm. bulb passed to right kidney. Phenolphthalein test was done intravenously. Appearance time right kidney was four minutes. Total excretion for right kidney first hour 50%. Left kidney did not show a trace of phenolphthalein.

Operation at St. Luke's Hospital on December 26, 1922. Left ureteral lithotomy. Low left incision was made. Stone was removed by incision into ureter which was within an inch of bladder. Patient had an excellent recovery and health has been good since leaving hospital.

Case D: Patient, Mr. S., male. Age 32. Occupation, fireman.

Family history: Negative.

Diagnosis: Left nephrolithiasis, left ureterolithiasis.

Chief complaint: Patient has had pain in left kidney region off and on for past two years. A stone was removed from left ureter by dilatation about one year previous. Six months ago patient took a trip to Atlanta in a Ford and was very sick there for three days. On return to Jacksonville patient was still very sick with pain in left kidney.

Cystoscopy on February 24, 1924. Dilatating left ureteral stricture relieved pain in left kidney although general health did not improve.

Cystoscopy on March 24, 1924. Phenolphtalein test was done intravenously. First hour right kidney excreted 54%. Left kidney did not show a trace of phenolphthalein.

Pyelogram shows a very large left kidney with stones in left ureter and left kidney, also showed a complete loop in ureter.

Operation at St. Luke's Hospital on March 25, 1924. Left kidney was removed, after which the patient recovered very fast and returned home on April 8, 1924. Patient has been well and working since leaving hospital.

Case E: Patient, Mrs. P., female. Age 26.

Family history: Negative.

Entered hospital on December 15, 1922.

Diagnosis: Double ureteral stricture. Double ureterolithiasis. Atrophy of right kidney.

Chief complaint: Patient has had spells of severe pain in kidneys for past six years and pain in right kidney for one and one-half years. Patient took morphine for the pain which subsided gradually and was fairly well until two months before entering hospital; at that time

began having pain in left kidney with nausea, vomiting, headaches, pain in hips and down left leg.

Past history: Negative except headaches all her life.

G. U. history: Patient has had bladder irritation all her life. No history of pus in urine.

Pyelogram made on December 16, 1922. Gives report of stone in both ureters. Large left kidney and no signs of a right kidney. In region of left ureter opposite body of fourth lumbar vertebra there is a stone triangular in shape one and one-fourth by one-half inches.

On right side is a stone four inches above the bladder in right ureter, a rounded stone one-half inch in diameter. Pyelogram shows the pelvis of the left kidney to be represented by six large round areas of erosion with destruction of kidney substance.

Cystoscopy on December 14, 1922. Bladder wall shows some edema and inflammation. A No. 9 renal catheter passed to left kidney meeting a definite obstruction. A phenolphthalein test was done. First one-half hour left kidney excreted 15%. Second one-half hour left kidney excreted 15%. Total phenolphthalein 30%. Appearance time left kidney twenty minutes. No trace of phenolphthalein from right kidney.

Operation on December 20, 1922. Incision was made to left of fourth lumbar vertebra. Stone easily removed by incision into ureter. Stone was not removed from right ureter. Patient had a good recovery and has been in excellent health since operation.

(2) Conditions resulting from ureteral strictures without stone formation.

Case F: Patient, Mrs. Q. Referred by Dr. J. B. Parramore of Jacksonville.

Family history: Negative. Age 28.

Diagnosis: Right urethral stricture. Right pyonephrosis.

Past history: Negative.

Chief complaint: Patient has had attacks of severe pain in right kidney region with fever, chills, nausea, vomiting, and has had five similar attacks in the past year.

Cystoscopy on November 7, 1922. Stricture of urethra was noted. A No. 9 Kelly cystoscope passed. Bladder wall shows some edema and ureteral orifices show edema and redness. A No. 8 catheter and 4½ mm. bulb passed an obstruction at two definite points in right ureter. Right kidney pelvis held 40 c.c. and on withdrawal of catheter a definite hang was gotten about 7 cm. from outside.

Pyelogram was made which showed left kidney normal. Right kidney is large and upper pole of kidney is at first lumbar vertebra, lower pole lies opposite the fourth lumbar vertebra. Ureter is dilated and is about one-half inch in diameter, has a complete loop in it.

Cystoscopy on November 18, 1922. A No. 9 Kelly cystoscope was passed. There was no change in condition of bladder. No. 9 renal catheter and 5 mm. bulb was passed to right kidney. Right kidney pelvis held 40 c.c. On opening ureteral orifice with a searcher, pus was drained from ureter. Since opening of ureteral strictures at former treatments patient states that she has been free from pain.

Cystoscopy on November 21, 1922. Findings were the same. A 4 2/3 mm. bulb was passed to right kidney. Right kidney pelvis held 90 c.c. Cloudy urine and pus drained from right kidney.

Cystoscopy on November 24, 1922. A differential phenolphthalein test was made; 1 c.c. of phenolphthalein was given intravenously. First one-half hour left kidney excreted 30%. Second one-half hour left kidney excreted 15%. Total phenolphthalein 45%. Appearance time left kidney three and one-half minutes. No trace of phenolphthalein from right kidney.

Guinea pig test was negative for tuberculosis. Culture showed staphylococci and a few bacilli.

Operation on November 27, 1922. Right nephrectomy. Patient had an excellent recovery and has been well since.

Case G: Patient, Miss S. Referred by Dr. H. B. Harkness, Lake City. Entered St. Luke's Hospital on January 22, 1926. Very weak. Temperature, 105. Pulse, 120.

Diagnosis: Double ureteral stricture. Left pyonephrosis.

Age, 35. Family history: Negative.

Chief complaint: Weakness, vomiting, loss of appetite, pain in right abdomen, right hip, epigastrium and in right leg.

Past history: Negative, except for headaches, indigestion, and constipation for the past five years. Patient gives history of having flu five years ago; at that time was in bed two or three weeks. Patient has not been well since that attack of flu.

G. U. history: There is no history of bladder irritation. Patient has never thought she had kidney trouble. Has been treated for pleurisy

on right side. In the last month doctor reported pus in urine.

Physical examination: Patient is well developed but shows some loss of weight and has a decided jaundice. General physical negative except severe pain and tenderness in right upper quadrant of abdomen.

Cystoscopy on January 22, 1926. Bladder wall was inflamed. A No. 9 renal catheter and 4 mm. bulb passed to both kidneys. A hang was gotten in both ureteral orifices as bulb was withdrawn. Differential phenolphthalein was done. Right kidney appearance time six minutes. 21% of phenolphthalein eliminated from right kidney first thirty minutes. Left kidney drained a thick mucus. No trace of phenolphthalein from left kidney.

Guinea pig test was negative for tuberculosis. Blood Wassermann was negative. Widal negative. Culture from bladder and left kidney showed staphylococci.

Pyelogram on January 28, 1926. Shows left kidney shadow to be approximately nine inches long and five inches wide. Entire ureter is about twice normal size. Pelvis and calyces show extreme dilatation. There is no evidence of urinary calculi. Injection did not fill pelvis and calyces completely.

Cystoscopy on January 29, 1926. No. 9 renal catheter and 5 mm. bulb was passed to both kidneys. General condition has gradually improved. A definite obstruction was noted and a definite hang was gotten in both ureteral orifices.

Cystoscopy on February 8, 1926. No. 10 renal catheter and 5 1/3 mm. bulb was passed to both kidneys. A differential phenolphthalein was done. Right kidney first one-half hour excreted 30%. Appearance time right kidney four minutes. Left kidney did not excrete a trace of phenolphthalein

Operation on February 10, 1926. Left nephorectomy through the usual lumbar incision. Patient's recovery was good. She left hospital on February 25, 1926. Patient gained weight and general health is good.

Case H: Patient, Mr. M. Reported to me on May 23, 1922.

Diagnosis: Double ureteral stricture with ulceration.

Age, 35. Family history: Negative. Past history: Negative.

Chief complaint: Patient has had severe hemorrhage from bladder, but has never suffered pain in kidney or bladder region.

Cystoscopy on May 24, 1922. Shows a definite drainage of blood from both ureteral orifices. No. 3 mm. bulb on bougie could not be forced to either kidney. No. 7 bougie was then passed to both kidneys, also No. 8 bougie was passed to both kidneys. After passing bougies there was so much bleeding from ureters it was impossible to pass catheter to either kidney.

Cystoscopy on June 20, 1922. Bladder wall was normal. A No. 6 and No. 8 bougie again passed to both kidneys. A definite obstruction was noted on passage of both bougies. A No. 6 renal catheter passed to right kidney. Patient's right kidney pelvis held 14 c.c. Patient seems to get no relief from hemorrhages from former cystoscopies.

Patient had cystoscopies at intervals between May 24, 1922, to September 12, 1922, with very much cessation of hemorrhage. On September 12, 1922, a catheter was passed to both kidneys and pyelogram was made. No definite pathology was noted with X-ray. No stones diagnosed. Patient gained in strength and there has been no subsequent hemorrhage from bladder.

I wish to emphasize the following points in connection with these cases:

1. Ureteral stricture ulcers with hemorrhage explain cases known as idiopathic hæmaturia.

2. Stasis of the urine will cause stone formation with or without infection.

3. Ureteral strictures may cause pyonephrosis or hydronephrosis with cessation of kidney function.

4. In pyelitis where there is good drainage the kidney will generally clear its infection rapidly.

5. In dilatation of the ureteral stricture in pyelitis the same result is obtained as in the opening of an abscess.

6. If good drainage of a blocked kidney is obtained the function will gradually increase to a certain per cent, dependent upon the degree of destruction of the kidney cells.

7. A thorough dilatation of ureteral strictures in hydronephrosis or pyonephrosis relieves pain.

DISCUSSION.

Dr. B. F. Woolsey, Jacksonville:

I certainly want to congratulate Dr. Teeter on the splendid number of cases he is able to present. Personally, I have not seen so many cases as Dr. Teeter, either in hospital or private practice. However, they are recognized more generally now than they used to be.

Ureteral stricture as a definite clinical pathological entity can no longer be questioned.

I would like to add a word of caution to the inexperienced cystoscopist. Ureteral stricture is identical with stricture of the urethra, and in my opinion, a diagnosis of stricture of either the ureter or urethra should only be made with the acorn-tipped bougie. As the bulb of the bougie passes the stricture a decided "grasp" or "hang" is felt by the examiner, both on entrance and withdrawal. As Dr. Walther so aptly states, "A ureteral stricture cannot be diagnosed by a No. 6 F. ureteral catheter."

Dr. Teeter has covered the pathological aspect in his article and his roentgenographic studies are quite complete. Unfortunately it is rather difficult to demonstrate the actual stricture by X-ray, but the resulting pathology is well shown The pathological results of ureteral stricture are namely: inflammation, either acute or chronic, infiltration, scar and contracture. Alterations in the calibre of the canal affect the ureter above and below the stricture and the result is dilatation above and atony below, with more or less intermittent or chronic discharge of mucus, pus, or blood, the same as in urethral stricture. In the kidney, the result of ureteral stricture is at first dilatation of the pelvis and then hydronephrosis and finally pyonephrosis. A partial stricture which suddenly becomes complete produces a cessation of renal function.

Dr. W. R. Jamieson states that in some cases the inflammation may come from contiguous structures and be limited to the peri-ureteral tissue. He refers to another observer who studied the lower end of ureters in the bodies of 25 patients with cystitis, dying from other causes, and in all he found changes of an inflammatory type in the submucosa and muscularis. He expressed the opinion that the inflammation extended along the lymphatics and not the mucosa. So, there seems to be some variation of opinion on the subject of the real pathology.

Strictures may be annular in contour or may be of the linear type, but they are usually of the former. They may vary from a soft infiltration to a hard dense fibrous scar formation one cm. or more in width.

Dr. Teeter has covered the treatment very thoroughly, so I will not go into it except to say that an early diagnosis is most essential to obviate renal complications such as Dr. Teeter has shown. Various dilating instruments are on the market, which when used properly, give fairly satisfactory results. Of course the resulting renal complications must be taken care of if damage has been done there by stone or infection.

I see frequent mention by the French urologists of using "electrolysis" for dilatation of strictures. This is not in general use in this country. Personally, I have never tried it, and would like to know if Dr. Teeter has, and if so, what his results have been.

CONCLUSION.

Dr. Edmund H. Teeter, Jacksonville:

Gentlemen: I hope that you have received something from this paper.

First, I want to thank Dr. Woolsey for his discussion and Dr. McEuen, who helped me to get up these lantern slides.

I just want to say that the kidney tract is a big field and we have not done it all yet. There are thousands of people who are suffering from some kidney tract condition. If we keep our eyes open, we will find many that we have missed in the past.

ANTERIOR POLIOMYELITIS OR INFANTILE PARALYSIS*

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Jacksonville.

Of all the deformities, both congenital and acquired, which the orthopedic surgeon is called upon to treat, the great majority of them result from the ravages of infantile paralysis. Over half of the cases I have seen in Florida are old poliomyelitis cases. We have new cases occurring every year and last year there was probably two hundred new ones added to the list. The disease is endemic here in Florida; although it appears in epidemic proportions at times. It seems proper that we should discuss this disease now, because I am persuaded that the majority of the deformities we are called upon to treat could have been prevented with proper care, and that many cases of extensive paralysis would be much less severe if the general practitioner had advised them more wisely. For it will always be the family physician's duty and privilege to guide these patients through the critical convalescent stage.

It is an acute infectious disease that involves principally the nervous system, and especially the spinal cord. It is caused by an ultra-microscopic germ or virus, which apparently gains

*Read before the Staff of St. Luke's Hospital, Jacksonville, November, 1926.



CASE NO. 1.—Left leg flail and useless. Walks without crutches and very little limp after one foot operation and the use of a leg brace for weak knee.

entrance through the upper respiratory tracts. It spreads along the lines of human travel during an epidemic. Transmission of the disease is by direct contact, and also by intermediate carriers, who are not susceptible to the disease. One attack confers immunity, while with increasing age there is an increasing acquired immunity. It is principally a disease of childhood; seventy-five per cent of all cases occurring before the seventh year. It is seldom that more than one member of a household is affected in the same year. Monkeys are susceptible to the disease, and it can be transmitted from one to another through the injection (intraspinal) of spinal fluid or salivary secretions during the acute stage. Recent cases are contagious as long as the nasopharyngitis persist; and should therefore be quarantined from two to three weeks, or until nasal discharges cease. All "contacts" should be isolated from other children. The incubation period is four to fourteen days.

The pathology is that of an acute interstitial meningitis, especially on the anterior surface of the spinal cord. The cord shows hyperemia and round cell infiltration, or perivascular infiltration. There is an extensive edema and many minute hemorrhages, particularly in the anterior or motor area of the cord. The damage to the cord results from three causes: first, direct pressure on the nerve cells by hemorrhage, edema and exudate; second, anemia, due to pressure on blood vessels; third, to direct toxic action on the nerve cells. The involved nerve cells may be out of commission temporarily only, but if the anemia and edema persist too long, there is permanent death of the motor nerve cells involved, and the paralysis is permanent.

SYMPTOMS.

We can divide these into three stages. It is necessary to consider the symptoms more in detail in order to discuss the treatment properly.

The state of onset is generally characterized by a high fever of 103°-104°, which subsides gradually in from three to five days. Gastro-intestinal upsets are very frequently the outstanding symptom, with nausea, vomiting or diarrhœa. There is sweating, nervous irritability, and sometimes convulsions. Stiffness of the neck muscles is frequently encountered. Hyperesthesia of the nerve trunks and muscles involved is a rather constant finding in the acute stage. Some few cases, however, have none of these premonitary symptoms; and the paralysis is the first thing observed.

The second or convalescent stage lasts for about two years. The edema of the cord or meninges gradually subsides; the hemorrhages are slowly absorbed, and the small cell infiltration diminishes, until the motor area of the brain can send impulses out to the affected muscles. This clearing-up process, together with the formation of new association tracts, lasts for about two years; although the most rapid improvement is seen in the first six months after onset.

The third or chronic stage, succeeding the convalescent stage, begins about two years after onset and remains practically unchanged. The destroyed areas of the cord show only glioses. No further spontaneous improvement occurs, except from treatment. Tendon contractures and deformities from muscle unbalance gradually develop. The paralyzed limb is atrophied and feels cold and clammy and looks bluish, due to poor circulation. The muscles are soft and flabby. There is no loss of sensation. The poor circulation is due to vaso-motor disturbance, as well as to loss of muscle functioning. The degree

of retardation of growth depends upon the extent of the paralysis, and upon the age of onset. The leg paralyzed at one year of age is much worse atrophied than the ten-year-old child's would be. The degree of deformity or crippling is determined largely by the muscular unbalance, as well as by the extent and location of the paralysis. An active muscle with its physiological opponent paralyzed, is more of a deforming factor than if both were gone.

The third or chronic stage is the proper time for restoring muscle balance, so far as possible, by transplanting muscles, stiffening or bracing flail joints and lengthening shortened tendons, or other corrective and educational treatment.

DIAGNOSIS.

At the stage of onset there is little that is characteristic from any other acute infection. During the summer months, any obscure fever or infection in a child should make one suspicious; especially if there is an epidemic of anterior poliomyelitis. If the patient is nervous, irritable, hyperesthetic, or has a stiff neck, a lumbar puncture should be done. This is the only way of diagnosing any case before the paralysis occurs. Slight paralysis or abortive cases then will not be overlooked and isolation can be instituted at once.

The spinal fluid in acute poliomyelitis is clear, colorless, and under slightly increased pressure. There is an increase of cell count sometimes up to 1200 per c.c., which is of the small mononuclear leukocytes. This increased cell count persists for about one month. There is also a marked increase of globulin in early infantile cases. Besides the spinal puncture, tenderness is one of the most constant and characteristic signs of poliomyelitis. Hyperesthesia is seldom absent, especially in the muscles paralyzed. After the paralysis appears it is recognized as being a *pure* motor flaccid paralysis of erratic distribution. Weakening or partial paralysis is more common than total paralysis. The reflexes are abolished or weakened; the reaction of degeneration is present after about one week; while the muscles soon become atrophied.

Nerve lesions, resulting in paralysis from *other* diseases like transverse myelitis, hematomyelia, or peripheral nerve lesions are usually accompanied by sensory disturbances. Multiple neuritis generally is gradual in onset and a sequelæ of some bacterial or metallic poisoning. Lead and arsenic palsy usually affects the extensors of



CASE NO. 2.—Talipes equinus—right foot. Before and after operation.

the wrist and is symmetrical. The history of infectious diseases, like diphtheria, should give us a fair idea of the nature of such paralysis. The history and distribution of obstetrical paralysis should give us little trouble in making a diagnosis. Occasionally we see a pseudo-paralysis occurring in constitutional diseases like rickets. A pin prick in the supposedly paralyzed limb will generally eliminate poliomyelitis from consideration. Spastic paralysis of cerebral origin, regardless of the etiology, probably is not epidemic poliomyelitis. Occasionally there is seen a cerebral type of poliomyelitis which may affect the cerebral meninges or the motor area of the cortex of the brain. This usually results in a hemiplegia, with a variable amount of spastic paralysis and cerebral incoordination. It is not within the province of this discussion to take up the several types of cerebral poliomyelitis now recognized. The high points to remember in making a diagnosis are few, but definite. Infantile paralysis is a *pure* motor flaccid paralysis of irregular distribution; usually affecting a child in the summer months.



CASE NO. 3.—Club foot of severe degree on left and right flat foot. Corrected by one operation on right and two operations on left.

THE PROGNOSIS

As to life, statistics give not over twelve per cent as an average mortality. If all cases were recognized, it would probably be even less. The prognosis as to function depends upon the location and extent of the original paralysis, and age of onset, as well as upon the subsequent treatment. All cases have some spontaneous improvement, with no treatment at all. With proper treatment the percentage of improvement is greatly increased, while many of the later disabling deformities can be prevented, or if allowed to occur, can be corrected in most cases. Twenty-five per cent of all cases recover entirely.

Before taking up the treatment it seems proper to consider the distribution of the paralysis and the types of deformity resulting from the paralysis. The lower extremities are far more frequently paralyzed than the upper. Of 2418 cases reported by several authorities, 1765 had permanent paralysis in the lower extremities only, as compared with 195 cases in which the arms alone were involved. The deltoid muscle is more often permanently paralyzed than any other one arm or forearm muscle. The extensor muscles are more often involved than the flexor groups, in both extremities. In the thigh the quadriceps is most often paralyzed. The lower leg is the most frequent site of permanent paralysis and here again the anterior or extensor group of muscles are affected much oftener than the posterior or flexon group of muscles.

The deformities resulting from anterior poliomyelitis are caused by: 1. Force of gravity. 2. Unopposed muscle action or unbalanced muscle power, and, 3. By functional disuse in abnormal postures or positions. Talipes equinus is found most often of all deformities. Talipes valgus, or flat foot, is the next most common deformity. Both are due to partial or complete paralysis of one or more of the anterior or extensor muscles of the foot. Talipes calcaneus is not as often seen as is club foot. Occasionally we see knee flexion deformities, due to contracted hamstrings, but most often the knee has no extension power, from paralysis of the quadriceps. Flexion deformity of the hip is a very common occurrence. Lateral curvature of the spine is a frequent and very troublesome deformity, which tends to increase with age, due to gravity and unbalanced muscle pull on the flexible vertebræ column. The upper extremities seldom present correctible deformities. The loss of abduction power with a weak shoulder girdle, especially the deltoid, is undoubtedly aggravated by gravity, pulling constantly on weakened muscles. The elbow never presents any deformity other than weakness. Wrist drop is seldom encountered, but loss of ability to oppose thumb and fingers is not a rare disability.

Facial paralysis is very rare and always recovers. Involvement of the external respiratory muscles is a serious occurrence, and is the usual cause of death in the acute stages.

TREATMENT.

In the acute stage this concerns the medical man or practitioner more than the orthopedist. Treatment is largely symptomatic in the febrile stage. It should consist largely of rest, and avoidance of irritation. Saline catharsis seems rational to reduce the edema of the cord. Lumbar puncture also relieves the increased intraspinal pressure as well as confirms the diagnosis. Hexamethylamine is the only drug indicated, which theoretically retards or inhibits spinal infection. Serum from patients who have had the disease, if given *early*, appears to arrest or abort some cases. Brilliant results have been reported

during the past year from this form of therapy. A serum is now on the market, but its value is not conclusively proven yet.

Fixation of the paralyzed and tender muscles in well padded plaster cast is desirable in the acute stage. When the trunk or neck is involved recumbancy on a Bradford frame is the best method. Warm saline baths and local heat to maintain circulation improve the nutrition of the affected parts. Massages and exercises of all kinds should be strictly forbidden until all muscle tenderness has disappeared. The tenderness will be unduly prolonged or will return if massage and active use is begun too early. Massages only irritate an already inflamed or hypersensitive nerve ending, coming from an inflamed area in the spinal cord. It is just as illogical or anti-physiological to use the tender or inflamed muscles as it is to use or irritate an acutely inflamed joint.

I do not expect all of you to agree with me, but I feel quite positively that there is no benefit at all to be derived from the use of electricity in any form, in the treatment of infantile paralysis. On the contrary it is definitely harmful in most cases. This is quite the opposite opinion with the general public, and also of most of the profession. Electricity is not tolerated well by children, and their cooperation is immediately lost. Exercises should be voluntary or with brain and muscle coordinating. The sudden violent contractions caused by electrical stimuli may actually rupture a damaged muscle, or at least drive it to work beyond its capacity. Because one muscle is dead, another one-tenth normal in power, while a third muscle, all of the same group, may not be affected at all. The current cannot be regulated to the individual muscles and one is greatly over-stimulated while the one next to it has not enough stimulus to exercise it. The use of electricity as a therapeutic agent has been entirely abandoned in the larger clinics, especially in the acute and sub-acute stages. The most important part of the treatment, for the early stages at least, is the prevention of deformity, which otherwise inevitably results. If the trunk is involved, recumbancy should be enforced, until recovery or until properly braced. If there is wrist drop, cock-up splints should be applied. Deltoid paralysis is best treated by a platform or obduction arm splint. The legs and feet should be supported in the neutral position; namely, thighs



CASE No. 4.—Extensive paralysis of both legs and trunk muscles with multiple deformities. Quadruped type of locomotion.

extended, knees straight and foot at right angle to the leg. The leg can be adequately protected from over-use and from developing deformities by keeping it fastened in a posterior wire splint with foot piece attached to prevent drop foot. Bracing should be continued as long as there is any tendency towards developing deformity.

Massages, very light at first, can be instituted as soon as all tenderness disappears. Active and passive motion should be done daily up to the point of fatigue. The pernicious practice of trying to make a child walk when the leg muscles are one-half to one-tenth their normal strength, cannot be too strongly condemned. This is a point most of us must unlearn. We are taught that to exercise a muscle is to make it bigger and stronger. This is true to a degree. But to work a sick muscle beyond its capacity or to the point of exhaustion, weakens it still more or may actually kill it permanently. No walking should be permitted until the muscles are practically back to normal, or are properly protected by braces. After walking is resumed there is almost no further return to power of paralyzed muscles. While often weakened muscles become permanently disabled from overwork or stretching, when used too soon or improperly braced, there need be no fear of stiff joints resulting from prolonged disuse, for it doesn't occur in infantile paralysis. The best thing to do in most cases is the hardest to do, and that is to do nothing in the way of walking or standing for six months to one year.

TREATMENT.

The subacute stage is largely orthopedic. No definite outline of treatment can be formulated on paper for the subacute cases. The more severe the disease the longer should be the convalscent period. Walking is to be allowed only when there is no marked muscle weakness, or only when well braced. This is particularly true of the first year after onset. Weak muscles can be permanently paralyzed if used too long or too vigorously. Deformities are much easier prevented than they are corrected. Exercises of weak muscles should be given daily to the point of fatigue—but should not be used to the stage of exhaustion. There should be no cutting operations for correction of deformity during the first year and very few during the second year. Wait till all hope of further recovery of paralyzed muscles returning to life has vanished. There is one point I hope to impress on you, and that is, that to *overwork* a weak muscle will only make it weaker instead of stronger.

The indications for treatment in the third or chronic stage are two: 1. Correction of acquired deformities and prevention of further deformities. 2. Balancing of muscle power and increasing the efficiency of what power remains. Contracted tendons, joint capsules, fascia, etc., can be gradually corrected by stretching in most cases, for from one to two years after onset. Later, as the contracture becomes more fixed and less elastic, tenotomies, tenton lengthenings, fasciotomies, and stripping operations are resorted to. Deformities from joint subluxations, or dislocations require orthopedic operations many times. Where operative stabilization is not possible, braces must be used to stabilize joints and prevent deformities. In some cases we use the bone skeleton for braces, and arthrodese joints that can be sacrificed. Arthrodesing operations are most feasible in the foot, where the majority of our deformities occur. Occasionally we find it advantageous to stiffen *one* knee or hip, shoulder, elbow, or wrist, when they are flail and not easily braced. Recently spinal fusion has come into rather general use as a means of bracing a curved spine, which we cannot hold otherwise. There is practically no deformity of the foot which cannot be largely corrected, and maintained, to look like a normal foot in a shoe; even though there is not a flicker of muscle power below the knee. Tendon transplantation of live or active muscles to take the place of paralyzed muscles has not proven to be as useful a procedure as it first promised. Making a flexor muscle out of an extensor muscle, or vice versa, is anti-physiological, and it is hard to educate such a transformed muscle to function properly. Besides there is generally a loss of power in such



CASE NO. 4.—After stabilizing right foot and double hip operation to correct thigh flexion. Walks very well with crutches, corset and double leg braces.

transplantations. For a drop foot deformity we can sometimes use the long toe extensor tendons as stay ligaments by fixing them into the bone just above the ankle, or we may stiffen the mid-tarsal joint with benefit. A transplanted peroneal tendon to take the place of a paralyzed anterior tibial muscle, with flat foot works beautifully sometimes. Valgus deformity, due to *over* acting peroneal muscles, is helped by removing the peroneals to a neutral position. In case of a calcaneus deformity, the peroneals or the posterior tibial muscle may be transplanted into the heel with much improvement.

For paralysis of the quadriceps muscle with a weak knee, we sometimes transplant one medial and the lateral hamstring into the patella. Transplantation of muscles about the hips and shoulders has not been of any material benefit. In the forearm and hand there are many combinations of transplants which can be worked out to advantage. Wrist drop can be overcome, and apposition of the thumb and fingers greatly benefited, in many cases. Results of tendon transplants in the hand are far more successful than anywhere

else, although it is seldom that we see cases involving the hand to any great extent. This is because the hand muscles are not overloaded or abused like those in the lower extremities, by walking too soon.

Braces are used to stabilize weak or flail joints, and to prevent deformity which cannot be corrected or prevented otherwise. Braces should not be used in the chronic stage whenever it is possible to avoid them.

CONGENITAL PYLORIC STENOSIS*

J. C. Davis, Jr., M.D.,
Quincy.

This condition was first accurately described by Beardsley, in 1788, but it remained for Hirschsprung, in 1888, to call the general attention of the profession to the present conception of the pathology. More recently the work of Weber, Ramstedt, Keefe, Downs, and others is to be commended, as it is through their work and efforts that we have been able to reduce the mortality to practically nil.

While formerly this condition was considered quite rare, owing to the simplicity of operative methods, awakened interest in the subject and a closer study of the symptomology, we now realize that it is by no means a rare condition but, heretofore, simply overlooked.

The typical, classical text-book symptoms are not always present and identical, but the majority of cases present the following classical conditions: More common in males, first born and by some authors more frequent in those artificially fed and others those breast fed. In the first stage there are no symptoms, *i. e.*, there is a period when undoubtedly an anomaly exists, prior to the development of clinical symptoms. The disease usually declares itself between the eighth day and eighth week. Vomiting ushers in the symptoms and is a characteristic feature. It occurs shortly after nursing, after each, or only after several feedings. The vomiting is forceful and projective, the stomach contents being sometimes expelled several feet from the infant. The quantity, as a rule, is large and represents the entire feeding. On account of the frequency of vomiting the patient is persistently hungry, although not infrequently anorexia; the child's nutrition suffers; there is a loss of weight, and often emaciation; weakness supervenes. Later on, especially when dilatation occurs, there are signs of retention, the urine is diminished in quantity, the tissues are dry, there is constipation and evidence of toxemia. The epigastrium is prominent, visible peristalsis may be seen in the abdomen and not infrequently a tumor is palpable, usually about the size of a walnut. The typical syndrone may occur without evidence otherwise of pyloric stenosis.

With the above symptoms, evidence of mechanical obstruction is unquestionable. There are cases that are reported with spitting of blood-tinged fluid the first day after birth, persistent diarrhœa and anorexia, no pain, the stools green and yellow with fat curds.

It is a clinical fact that a number of children presenting these symptoms have been cured by medical treatment or recovered in spite of medical treatment without surgical interference. Yet to my mind, these were not true cases of pyloric stenosis but merely cases of pylorospasm, which is brought about by local irritation of the mucosa of the pylorus, as occurs in erosion, fissures, ulcers, neoplasms involving the pylorus or by conditions associated with gastric hyperacidity or by reflex irritations from inflammatory conditions elsewhere in the abdomen as frequently observed in disturbances of the duodenum, diseases of the biliary tract, the pancreas and the appendix. There are, however, instances of functional pylorospasm which are in all probability the result of excessive vagal stimulation.

Differential Diagnosis: (1) The possibility of mere indigestion excludes the usual signs of stenosis; (2) congenital atresia of the duodenum. This may simulate congenital pyloric stenosis. The patients, however, usually live only a few days. The vomiting is usually bilious in character in contra-distinction to the absence of bile in a true stenosis of the pylorus, though this depends on whether the obstruction is above or below the common duct. (3) pylorospasm.

Treatment: In all cases it is advisable to try medical treatment first. This should be done in order to complete the differential diagnosis. Hutchinson recommends the following regime: (1) Regulate the diet, so that the child is fed small quantities at frequent intervals, (2) lavage of stomach once or twice daily, (3) small saline enemata (2 oz.) twice daily to make up for loss of fluids. If there is no improvement in three or four weeks, surgical treatment offers the only probability of a cure.

Most authorities agree that if after ten days

*Read before the Second District County Medical Society, Tallahassee, June 14, 1926.

the treatment is unsatisfactory, operation is indicated. All in all, medical treatment is of no avail where a definite stenosis exists. Of all the drugs that have been recommended, atropine is, perhaps, the only one from which beneficial results can be expected. It can be given in the form of drops added to the feedings, from two to ten drops of a 1-1000 solution being used in twenty-four hours. Warm compresses may afford some relief, and should be applied with a binder.

Surgical Treatment: The indications for surgical treatment are: (1) Persistent vomiting, (2) absolute constipation, (3) poor general condition, (4) evidence of obstruction. Operation should never be performed as an emergency, patients should always be carefully prepared with lavage and infusion for at least four days if possible.

The essentials of the technique in operation are: (1) Gentleness, (2) speed, (3) local anesthesia, (4) minimum manipulation, (5) incision as near convex upper surface as possible, (6) division of tumor along entire length, (7) control of bleeding with a few mattress sutures (00 Gut).

The technique of the Ramstedt operation and the after-treatment will be covered with a report of two cases that I personally operated upon as follows:

Case 1: Baby G. G. Date called, April 21, 1920. Date operated, May 11, 1920. Male, breast fed, second child, weight at birth eight pounds. Illness began at five weeks six days, weight twelve pounds. The child was healthy and vigorous up to the time the vomiting began. The vomiting was of sudden onset.

I saw this child in consultation with Doctor Galphin, of Havana, four days after onset. At this time the child had vomited after each feeding, which was projectile in character, had been obstinately constipated, diminished amount of urine. After exposing the child's abdomen and noticing that it was quite flaccid, I had them give the child two ounces of sweetened water and watched for the gastric wave. In less than three minutes after taking the water the child showed typical gastric peristalsis crossing the median line; this was so distinct as to cause a considerable bulging of the left rectus muscle with one continual wave after another for about ten minutes, when there was a reverse wave which emptied the stomach and the vomit projected two or three feet from the child. This clinched the diagnosis in my mind. No tumor was palpable at that time. According to the various authorities I had read on the subject since 1914, I reluctantly advised that we do a Ramstedt operation. This the parents did not see their way clear in submitting to without first a chance with medical treatment. With this condition staring us in the face, Doctor Galphin and I came to the conclusion that we would try liquid petrolatum in dram doses, three times daily, also two minims of benzyl-benzoate in sweetened water every four hours, with the idea, if this was only a functional reflex pylorospasm, that by gentle lubrication and relaxation we would probably theoretically be doing something. It is interesting to note that after this medication some food began to pass from the stomach to the bowels. Vomiting became less often and the child remained at a standstill in weight for one week, after which he began to lose two ounces daily for a few days, but going twelve hours without vomiting. In fact, at one time he went twenty-nine hours without vomiting and in two days gained four ounces, after which he began losing two ounces daily, until he weighed only nine pounds. At this time I was able to convince the parents that if the child was not gaining in weight he was losing, aside from the fact they could see the amount of daily loss. Three weeks now had elapsed since the beginning of the symptoms above mentioned. At this time I was able to palpate a small tumor at the pylorus. The child was brought to the hospital and a Ramstedt operation done.

A one-half of a one per cent novocain solution was the anesthetic employed. An incision two and one-half inches in the right rectus above the umbilicus was made. On examination, the pylorus muscle was found greatly enlarged and a very hard cartilaginous-like tumor was demonstrated. This was incised on the posterior part, beginning at the cardia side and extending toward the duodenum. The muscle was gradually separated from the mucous membrane in its entire length, so that the mucous membrane bulged at least one-eighth of an inch the whole length of the incision. The abdomen was closed in the usual manner. Operation was completed in fifteen minutes. The child suffered little shock and immediately after leaving the table was given one dram of mother's milk with one dram of barley water. Feedings were continued every three hours, increasing one dram of breast milk every other feeding until we were giving one ounce every three hours during the day and

every four hours at night. After five days the child was allowed to nurse the mother. Castor oil was given twenty-four hours after the operation. The child left the hospital on the tenth day with eight ounces gain in weight. The child made complete recovery and is now six years old and a fine boy.

Case 2: Baby L. D. M., male. First-born Weight at birth eight pounds. At one week child began having large wine-colored stools, three or four times daily. This condition persisted until the child was three weeks five days old, a doctor was called, he gave a bismuth mixture for diarrhœa. Child had been jaundiced throughout but had cleared up to return again, more marked than the first. The child began to vomit or spit up its food, occasionally at first. After the fourth week obstinate constipation began and everything taken by mouth came back immediately, rapid loss of weight, increased thirst and diminished and highly colored urine, gastric peristalsis but no projectile vomiting as in Case 1. Child just opened mouth and food poured out. Child given retention enemas of soda and glucose for one week. Tumor was not palpable until day of operation.

On fifth week, after one week of medical treatment and diagnosis unquestionable in my mind, confirmed by Doctors Moore and Mack, a two-inch right rectus skin incision above umbilicus was made, following infiltration of area with one-half of a one per cent novocain solution. The pylorus was fixed by adhesions well under liver in close proximity to gall bladder. The entire pylorus was edematous and presented a glistening appearance as found in any constricted area before the onset of a gangrenous condition. After freeing the pylorus from its bed of adhesions the serous and muscular coats were divided along the convex curvature of stomach and the submucosa allowed to bulge well into wound the entire length of the annular muscle. Twenty c.c. of mother's blood was given subcutaneously at conclusion of operation on account of marked jaundice. Wound closed and same after-treatment as instituted in Case 1. Child made uninterrupted recovery.

Both the above were males, one first-born, the other second, both breast fed, one had diarrhœa and wine-colored stools accompanied with jaundice; the other persistently constipated. One had projectile vomiting, the other did not. The tumor was more easily palpable in Case 1 with a much smaller tumor. The development of the pyloric muscle accompanied by edema in Case 2 was probably due to pylorospasm induced by adhesions constricting pylorus and being twisted on itself.

Notice!

TO MEMBERS:

Your state dues are payable January 1st, 1927.

Take $10.00 or a blank check to the January meeting of your county medical society.

TO SECRETARIES:

Revise and bring up-to-date, the roster mailed to you December 20th.

One delegate to be elected for each twenty paid members or fraction thereof.

1926 MEMBERSHIP . . . 1108

1927 " ?

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PROTECTION BY VACCINATION

There is no law in Florida requiring vaccination against smallpox. During the calendar year 1925, 206 cases of smallpox were reported to the State Board of Health. So far this year, 2,746 cases have been reported and eight deaths have resulted, one of the deceased having been a school teacher. Those who are directing the education of our children certainly should believe in vaccination against smallpox. Eight is not as large a number as reported from many other causes. However, when protection against smallpox is right at our door, it seems criminal for eight deaths to occur from this cause in our wonderful state of sunshine.

Press release bulletins Nos. 12 and 14 from the Conference of State and Provincial Health Authorities, on "Saving Money on Smallpox" and "What Might Happen Without Vaccination," by Dr. Hugh S. Cumming, surgeon general of the United States Public Health Service, emphasizes in a very striking manner the necessity of vaccination against smallpox. Extracts

from these press releases are quoted as follows:

"We frequently hear someone express the idea that vaccination is just a plan of the doctors to get business. Such an idea is too absurd to discuss, for one has only to look up the facts in regard to the cost of vaccination compared with the cost of smallpox epidemics to a community.

"The Secretary of the Michigan State Board of Health stated a few years ago that it cost Michigan $150,000 a year to take care of indigent smallpox patients and to protect the unvaccinated. The Secretary of the Kentucky State Board of Health, in reporting upon an outbreak of smallpox in that State in 1901, said that the actual cash expended during that epidemic by counties and cities, on account of smallpox, was $308,271, not including the expense to individuals. The reported loss from interference with business was $734,000. This did not include the great loss to transportation companies from interference with travel and commerce. He says, 'these are the bare, naked figures in regard to the most expensive and widespread epidemic from which the State has ever suffered, and covers an experience which might have been easily avoided had heed been given to the united voice of the medical profession and the repeated warnings of state, city, and county health officers urging universal vaccination.' In a circular issued by the Kentucky State Board of Health entitled 'How to Combat Smallpox,' it is stated that smallpox during a period of a few years had cost county and city treasuries $515,775 actual cash and an estimated loss from interference with business and travel of $1,227,435. This circular stated that 'judiciously expended, this would be more than enough to keep every person in Kentucky vaccinated for a generation, so that the existence of anything but an imported case of smallpox would be an impossibility.'

"Professor Irving Fisher, in his report on National Vitality, states that the economic loss to Philadelphia caused by the smallpox epidemics of 1871 and 1872 was estimated by Dr. Lee at $22,000,000. In a bulletin (No. 7) of the Wisconsin State Board of Health, the statement is made that Saginaw, Michigan, spent $75,000 in quarantining and treating smallpox and that 48 citizens died of the disease. Grand Rapids, Michigan, a city over twice as large as Saginaw, spent $2,693 for vaccination and not a single case of smallpox occurred in that city.

"The Health Commissioner of the City of St. Louis said in an address before the Optimists Club in that city on December 11, 1924, that it cost the city more than $150 to care for every case of smallpox, but to prevent a case of smallpox by means of vaccination cost less than one-thousandth as much.

"The claim is made that vaccination is dangerous. The medical officers of the navy have vaccinated since 1917 approximately three-fourths of a million persons without a death. Medical officers of the army have, during this period, vaccinated five and one-fourth million persons. Only one of these nearly six million men died during the course of vaccination and this man died of pneumonia. The Detroit vaccination figures also show that practically anyone may be safely vaccinated against smallpox. There were 817,000 persons vaccinated in Detroit during 1924 without a death or serious accident. Of these about 500,000 were vaccinated in May or early in June. Smallpox had constantly increased up to the end of May. The outbreak terminated the latter part of July.

"The Detroit Health Department has figured out the time lost on account of 784 persons that had smallpox between April 13 and August 31, 1924, as 163 years, 8 months and 17 days. No attempt was made to figure out the economic loss by assigning an arbitrary earning capacity value to this time lost, but it is obvious that the economic loss was stupendous.

"Cold-bloodedly considered, these unnecessary epidemics do not pay. They are a cruel waste of hard-earned money, both of individuals and of the state."

STATE NEWS ITEMS.

Dr. and Mrs. Albert McKenzie, who spent several weeks in Baltimore and Philadelphia, where they attended the Sesqui-Centennial Exposition, have returned to Jacksonville.

* * *

The Manatee County Medical Society entertained the Sarasota County Society at the Dixie Grand hotel, November 16th. After the banquet, Dr. Gideon Timberlake, formerly of Baltimore, but now of St. Petersburg, gave a talk on hematuria. Drs. Feaster and Griffin of St. Petersburg were also guests.

* * *

Dr. and Mrs. Stephen Gyland of Tampa announce the birth of a son, November 18, 1926.

* * *

Dr. Alpheus K. Wilson of Jacksonville returned recently from a three-months stay in Vi-

enna, doing post-graduate work in eye, ear, nose and throat clinics.

* * *

Through the solicitation of Dr. Joseph Halton, Honore and Potter Palmer, of Chicago and Sarasota, have given to the Sarasota Hospital a complete X-ray department. This is one of the most completely equipped departments in the state.

* * *

Dr. and Mrs. E. L. Biggs of Starke left recently for a short visit in Havana, Cuba.

* * *

Dr. M. A. Lischkoff of Pensacola has been received as a fellow of the American College of Surgeons.

* * *

Dr. A. H. Freeman of Ocala has returned from a visit at Clayton, Ga.

* * *

The Volusia County Medical Society held its regular monthly meeting November 9, 1926, 6:30 p. m., at Cattaneo's grill, Daytona Beach. Dinner was followed by an interesting scientific and business meeting. The subject of the evening was "Better Meetings." The secretary, Dr. R. L. Miller, reports that, with twenty-two members present, this proved to be a very fine get-together, but better ones are being planned for the future.

* * *

Drs. Pennington and Pennington of Lake Wales have opened a private hospital at that place.

* * *

The November meeting of the Lake County Medical Society was held at the Bietarm Hotel, Tavares, with nine members in attendance. Dr. J. S. McEwan of Orlando read a paper on "Chronic Gall-Bladder Diseases" which was discussed by Dr. S. H. Hodgson of Clermont.

* * *

Drs. Jas. D. Love and R. H. McGinnis are now located at 1463 Oak street, Jacksonville, having removed from 501 Laura street on November 1.

* * *

Dr. J. M. Hoffman of Pensacola has been appointed acting secretary of the Escambia County Medical Society and will complete the term of the former secretary, Dr. Herbert Snyder, who has been forced to resign owing to serious illness in his immediate family. It is probable that at the time this issue of the Journal comes off the press, Escambia County will have reached the 100% paid list, inasmuch as but one member of that society was in arrears on December 1.

Dr. T. W. Causey's hospital at Lakeland was closed on November 10.

* * *

The November meeting of the Broward County Medical Society was held on November 9. Dr. C. D. Hoy, chief of surgery, White Cross Hospital, Columbus, Ohio, spoke on the "Treatment of Fractures of the Ankle and Wrist." Dr. A. P. Harrison, acting health officer of Ft. Lauderdale, submitted to the society an outline for a city board of health which was unanimously approved.

* * *

The Pensacola Hospital has been placed in the preferred classification by the standardization committee of the American College of Surgeons.

* * *

At the November meeting of the Orange County Medical Society, held at Sanford, November 17th, the members from Seminole County decided to break away from the Orange County Medical Society and form an organization of their own. With the assistance of Dr. Maurice E. Heck of DeLand, councilor for the Seventh District, a temporary organization was affected, and the following officers elected:

President—Dr. Sam Puleston, Sanford.
Vice-Pres.—Dr. J. W. Martin, Oveido.
Secy.-Treas.—Dr. Chas. Park, Sanford.

* * *

The Columbia County Medical Society held its regular meeting in the office of the Lake City Chamber of Commerce, November 1st, with Dr. J. H. Dyer of Lake City presiding. Dr. A. L. Blalock of Madison presented a paper. A lengthy discussion was held among the doctors.

* * *

At the November meeting of the DeSoto-Hardee-Highlands County Medical Society, appendicitis and diphtheria were the topics of discussion. Dr. M. L. Crum of Arcadia and Dr. J. E. Garner of Wauchula led the discussions, after delivering two well-prepared papers.

* * *

Dr. L. M. Anderson, councilor for the Third District; Dr. L. J. Arnold, secretary of the Columbia County Medical Society, together with the secretary-treasurer and business manager of the State Association, spent two days recently visiting physicians in Columbia, Madison, Hamilton and Suwannee Counties in the interest of the get-together meeting in Lake City, December 13th, for the formation of a multiple county society.

Dr. W. E. Van Landingham of West Palm Beach made a trip to Jacksonville recently to appear before the grand jury for the purpose of identifying certain papers in connection with the activities of the State Board of Medical Examiners in ridding the state of its "diploma mill" doctors.

* * *

Dr. Eugene S. Gilmer and Dr. Robert P. Henderson announce they have become associated in the practice of urology, with offices at 613 Citizens Bank Building, Tampa.

* * *

Dr. H. Mason Smith and Dr. Nathaniel L. Spengler announce the removal of their offices from 501 Stovall Building to 903 Tampa Theater Building, Tampa.

* * *

The marriage of Mrs. Helen M. Willis and Dr. S. B. Forbes on November 6th will be of interest to their many friends.

* * *

Dr. and Mrs. Forbes have returned from a motor trip through the mountains of North Carolina, stopping over in Atlanta and Athens, and are now at home at the Carlton Apartments in Tampa.

* * *

Congratulations to Dade County Medical Society. According to the records, Dade County Medical Society is first in total membership as well as paid members.

* * *

Dr. Clement Lanier Richardson of Jacksonville died December 3rd. He was eighty-five years of age and practiced his profession in Louisiana over fifty years. After retiring, several years ago, he came to Florida to reside with his son, Dr. Shaler Richardson. Dr. Richardson received his M.D. degree from the College of Physicians and Surgeons, Baltimore, and the M.A. degree from the University of North Carolina. He served in the Confederate army four years.

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FIFTY-FOURTH ANNUAL MEETING, W. PALM BEACH, APRIL 5 & 6, 1927

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CONTENTS

PAGE

Pyelitis Complicating Pregnancy 153
I. M. Hay, M.D., St. Augustine

Malocclusion 156
N. L. Spengler, M.D., Tampa

Synergistic Analgesia 159
C. J. Heinberg, M.D., Pensacola

The Diabetides 161
Spencer A. Folsom, M.D., Orlando

Vincent's Infection 164
J. C. Inman, Jr., M.D., Chattahoochee

PAGE

Editorials: (1) Articles of Incorporation, Florida Medical Association; (2) $100,000 Offered for Conquest of Cancer; (3) Florida's New Hospitals 167-170

State News Items 170

Advertisers' Notes 174

Schedule of Meetings, Component Societies of Florida Medical Association..... 175

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PYELITIS COMPLICATING PREGNANCY*

I. M. Hay, M.D.,

St. Augustine.

My reasons for bringing to your attention this not particularly unusual condition are threefold: In the first place because its etiology offers a speculative and interesting field for thought which has been stimulated of late by increasing data on the subject. Secondly, because through some decided peculiarity of the condition it is very frequently confused with other diseases. Indeed, Kretschmer and Heany[4] have recently shown that pain from an enlarged pelvis may occur in the absence of pus in the urine. Small wonder then that normal appendices are occasionally found when laparotomy is performed for such pain! Thirdly, because in the treatment there is considerable divergence of opinion. If pus is found in the urine of gravida, should one immediately employ operative methods to clear up a ureteral kink, stricture or an infected pelvis, or is it preferable to wait until pyelitis is symptomatically established? Even then is palliative or operative treatment most effectual?

The older views concerning the cause of pelvic infection during pregnancy turn to the seemingly obvious fact that an enlarged uterus should logically cause pressure on the ureters. This theory has been untenable to De Lee,[1] who in the 1925 Year Book states: "The old notion that the gravid uterus 'presses on' the ureters seems to still possess the minds of many. The specific gravity of the gravid uterus is no greater than that of the intestinal mass and less than that of many tumors which fill the lower abdomen." He recently removed an ovarian cyst weighing over twenty pounds. The belly was so distended that the skin shone, yet the ureters were not dilated.

Hunner[2] found that among 35 cases of pyelitis of pregnancy all but one had ureteral strictures. Some of these patients gave a history of pyelitis during a previous pregnancy, being symptomatically free with normal urine during the interim. From these studies he believes that the chief value of ureteral catheterization lies in the dilatation of the strictures. When this is accomplished it is not necessary to continue treatment until the urine is free from pus. Another author[1] observes that lack of drainage in his cases was due to dislocation of the ureter and not to stricture.

Young, in his new Practice of Urology, states that residual urine is very frequent during and after pregnancy. He assumes from this that a hypotonic condition of the bladder plays a more important role in this condition than obstruction.

A twist in the ureter caused by the ascending uterus is often given as an etiol factor, while some believe that the condition is especially prone to occur in those with movable or dropped kidneys. Kinks in the ureters have been considered as a frequent cause of pelvic obstruction. Kretschmer and Heany[4] believe the kinks to be the result of ureteral dilatation and not a cause for this dilatation. The kinks were not present in pyelograms made after delivery. In a study of twelve cases of pyelitis with the aid of pyelography these authors found dilatations of the affected ureters in each instance. This interesting information led them into a study of the pelves of normal pregnant women, in an endeavor to ascertain whether dilatation occurred only in cases with pyelitis, or whether it occurred commonly in pregnancy and was, in consequence, a predisposing factor in causation of pyelitis. In a study of normal pregnancies they found that four out of every five showed an easily ascertainable dilatation of the ureter and kidney pelvis or of the kidney pelvis alone. They believe that a good many of the obscure abdominal pains that patients have during pregnancy are attributable to dilatation of the urinary tract.

All of which leads one to the following conclusion in regard to etiology: That during pregnancy the ureters and pelves very often become dilated, thereby furnishing an inviting field for invasion by bacteria, especially the colon bacillus, but that as to the cause of the dilatation, and why it should occur with more frequency on the right we are certainly still in the dark. However, it would appear from the data at hand that the cause is one directly associated with an ascend-

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, Fla., May, 1926.

ing, pregnant uterus. That is that there are certain factors concerned that do not exist in instances of other abdominal tumors of the location.

Before discussing the treatment I wish to summarize two cases of pyelitis of pregnancy which have been under my care in the past six months.

Mrs. M. entered Flagler Hospital on January 22, three months pregnant. For three weeks previous she had had urinary frequency and slight urgency. Pus was found in her urine and a doctor had irrigated her bladder to relieve the cystitis. When I first saw her she was complaining of terrific pain in the right side, had considerable fever (102½) and urine was heavy with pus. This was her first pregnancy and there were no points of significance in her past history. The case was obviously one of pyelitis. The patient was put on palliative treatment consisting of caprokol (Hexyl Resorcinal), ice pack to back, lying on left side. Under this treatment for four days she became much worse. Both ureters were catheterized and pus was found in the urine from the right. An autogenous vaccine was prepared from a colon bacillis culture obtained in pure state from this urine. The catheter was left in place for 36 hours when it had to be removed due to pain. The pelvis was lavaged with mercurochrome three times. Catheterization was repeated one week later and a third time six days after the second. The catheter was retained twelve and thirty hours respectively and lavage repeated. She had run a very septic fever during this period, but it declined regularly after the last lavage and drainage. She was discharged February 21st with a normal temperature but with urine still containing numerous pus cells. Since then she has been in very good health and we expect no trouble in her delivery which should take place in July.

Mrs. G. was admitted to Flagler Hospital March 27, 1926. She was about 7½ months pregnant and had had a very stormy time of it. During the second month of her pregnancy a doctor found pus in the urine which was treated with urotropine and sodium acid phosphate. Nausea became more marked as she advanced toward term. A low grade fever began during the fifth month which followed a septic course, intermittent in type. The patient became rather drowsy as her illness progressed and this symptom was especially marked on her admittance. Ureteral catheterization was done in February, pus being obtained from the right kidney, the pelvis of which was treated by mercurochrome. This was repeated two weeks later. Since that time she has not improved and last two weeks has steadily declined in health and spirits. She had scarlet fever and typhoid as a child. In 1922 a two months' pregnancy was aborted for kidney infection. Her condition when I first saw her, on her admittance to the hospital, was grave. Specimens of urine from each kidney, obtained by ureteral catheterization, were heavy with pus. On the basis of this fact we considered abortion as the only rational method of procedure. Dr. E. S. Estes passed a catheter into the uterus and later extracted the fetus with high forceps. The child was living and apparently normal but died twenty-four hours later. Capronol and general medical measures were instituted. Patient continued to run some fever for about three weeks after her delivery. A month after her discharge from hospital she was in fairly good condition but still had an occasional pus cell in her urine.

Treatment.—As we lack information as to the exact cause of this urinary stagnation of pregnancy, so we lack exact or specific methods of dealing with it.

If pus is found in the urine during pregnancy with very mild or absent symptoms, should a careful urological examination of the bladder, ureters and pelvis be made? Rush of Mobile,[7] a urologist, is of the opinion it should be thoroughly investigated. Other urologists share this opinion. That it is best to make an exact diagnosis early in order to base subsequent treatment on a rational basis.

Opposed to this view are those[8] who believe that we should employ a policy of watchful expectancy. Hexamethylenamin should be pushed along with large volumes of water. In hexyl resorcinal we have a recent and very promising addition to the therapeutic armament. According to Leonard[10] urinary infections due to B Coli, and confined to the urinary mucosa from the renal pelvis down can be cleared up completely with no other treatment than hexyl resorcinal by mouth of the bacterial count if the urine is low. Henline[11] has had splendid results with hexyl resorcinal. In more severe cases local measures are necessary in addition.

In view of the work of Kretschmer and Heany[4] which clearly proves that ureters and pelvis are dilated in practically all instances, it follows that passing ureteral catheters is very prone to excite infection in the stagnated urine and their use for

other than minimum diagnostic purposes is questionable.

The treatment of clinically established pyelitis of moderate severity is also a matter of controversy. Shears[13] and Hirst[14] believe palliative measures, such as lying in bed on the side opposite that affected, ice bags, urinary antiseptics, etc., are alone indicated in all but the most serious cases. The advent of hexyl resorcinal has considerably augmented faith in this mode of treatment.

Hunner[2] believes that the ureters should be catheterized and dilated, thereby relieving the stricture which he holds to be responsible for the obstruction. Rush[5] used ureteral catheters for continuous drainage. A catheter was left in for 26 days in one instance with no resultant stricture. He does not advise lavage with drugs, relying solely on the drainage afforded. Some[13] take the position that pelvic lavage and catheter drainage is liable to do more harm than good unless in the hands of an expert. Distension of the bladder has been employed, hoping to excite peristalsis in the ureters, thereby furnishing drainage. For the more severe forms of pyelitis which verge into pyelonephritis radical measures are demanded.

Keyes states that if ureteral catheterization and lavage fail, the choice lies between terminating the pregnancy and nephrectomy. Inasmuch as the severe infection usually occurs late in pregnancy there is often no grave objection to terminating the pregnancy. Bilateral involvement calls for abortion in all cases not responding to less radical measures. In cases of unilateral infection severe enough to call for abortion Davis[15] holds that if any operation is to be performed it should be performed on the kidney, as induction of labor may only encourage delay in proper surgery.

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DISCUSSION.

Dr. Clarence D. Rollins, Jacksonville:

I just want to emphasize one fact that was brought out, that is, in pregnancy, whether you have pyelitis or not, a great majority of the cases have dilated ureters. It was recently proven by X-ray in a series of normal pregnancies that the ureters and hilus of the kidney are dilated in about eighty per cent of the cases, giving you a condition favorable to the development of pyelitis. I think that this is an important point for us to consider in the prenatal care of our pregnant cases. Having in a large majority of these cases a dilated ureter or dilated hilum of the kidney, due to anatomical and physical conditions of pregnancy, we must view these cases as a pre-pyelitis and treat them as such or we will have a pyelitis or pre-eclampsia to deal with. In obstetrics, we treat pre-eclampsia and avert the cause of eclampsia and I think now we will have to treat pre-pyelitis because in practically eighty per cent of pregnancies we have a dilated ureter which is a favorable condition for development of pyelitis. A great majority of these cases will result in pyelitis if we do not treat prophylactically by getting the patient in a condition that will favor removing the obstruction or pressure on the ureter. Put the patient to bed, alkalinize the urine and we may avert the cause of pyelitis in a great many cases. Of course if you do not treat these cases, or the preventive measures are unsuccessful, and the case goes on to actual pyelitis, it should then be treated expectantly. Most of the cases will recover under such treatment. However, there are a few cases that do not get better. The patient gets worse and loses weight and appetite, going down hill all the time. Such cases sometimes require radical treatment and nothing else will do. The best treatment in cases like that, I think, is a vaginal Cæsarean section up to twenty-two weeks. Of course after that time a bag might be practical as the cervix will probably open enough to permit the insertion of the bag. In cases under twenty-two weeks, vaginal Cæsarean section is the thing. All other forms of treatment produce a slow dilatation of the cervix, taking several days to bring the patient into labor with suffering all of this time, and consequently shock and exhaustion. Vaginal Cæsarean section is done quickly, without shock, and relieves the patient at once.

Dr. Edmund H. Teeter, Jacksonville:

I agree with Dr. Hay in this work on ureteral stricture, and if we take into consideration pregnant women and follow their history from beginning to end, we will note that in many cases they have had a pain, especially around the menstrual periods, and have suffered a great deal. Many times the ovary and appendix have been taken out, and they still have their ovarian pain, as they claim, at their menstruation. When they become pregnant, of course this pain continues. If you go back into their histories you will many times find that the patient has had this pain at menstruation. Undoubtedly, this pain is a flaring up of a chronic inflammation, or inflammatory condition of the ureter causing obstruction of the ureter and gives her ureteral or kidney pain which is referred to the ovarian region, and is mistaken many times for ovarian or appendix pain.

You cannot get dilatation of a kidney pelvis without obstruction to its drainage. If you have free drainage of the kidney pelvis you will not have stasis of the urine. This last year I had cases that did not have pyelitis but had stasis of the urinary tract. They gave their history and I told them they had obstruction to kidney drainage. I dilated the ureters and sent them home. They improved in health immediately after the ureters were dilated.

CONCLUSION.

Dr. I. M. Hay, St. Augustine:

Dr. Teeter made the remark that there is some obstruction or the ureter would not dilate. The point I wished to make is that as we have no accurate knowledge as to the location and nature of the obstruction, we can have no assurance that dilatation will give permanent relief. We do know that most pregnant women have dilated ureters which unquestionably gives them a stagnation of the urine and a very favorable medium for growth of bacteria. The prognosis is fairly good under ordinary systemic or conservative antiseptic treatment. A few of the cases, of course, demand more radical treatment but I believe the management should be more conservative than in corresponding cases in non-pregnant women.

MALOCCLUSION

N. L. Spengler, M.D.,

Tampa.

The first stages of dentition are indicated by a vague irritability of the child and a desire to bite. An increased flow of saliva and disturbances of the intestinal canal are commonly observed. The gums over the erupting teeth become raised and are darker than the surrounding tissue. If the process becomes abnormal, this area darkens considerably, due to increased inflammation, and the child shows a decided feverishness. When a tooth is further prevented from making its appearance, the overlying tissue becomes white, the blood being kept from these parts by excessive pressure from beneath. When such condition presents, the child experiences pain on biting instead of relief and refuses to nurse. It then becomes extremely irritable, cries lustily for a time and may subside into a semi-comatose state, or, in extreme cases, convulsions followed by coma. Skin eruptions and a cough often attend. Intestinal disturbances may also supervene and these disorders are probably due to micro-organisms which develop rapidly in the mouth at this time because of the inflamed condition. The irritated state of the mucosa, attendant upon dentition, encourages the growth of micro-organisms which do not flourish there normally, and their passage into the intestinal tract is followed by fermentation and decomposition, the products of which act is irritants and poisons.

That dentition should be attended with excessive pains which may result in convulsions, coma, or even death is not altogether surprising when we consider the facts.

To recall the conditions: we have a rapidly growing tooth being pressed toward the gum surface to make room for the developing root beneath. As each layer of dentine is deposited, the tooth is pressed on farther. The thick, well-organized gum over the tooth must be absorbed. If the child is in a healthy condition, this process goes on with comparatively little discomfort. However, if vitality is lowered and the circulation enfeebled or diseased, absorption of the overlying tissues does not keep pace with the development of the tooth, hence the area becomes inflamed, the blood stagnates, and as a result waste products are not properly removed; absorption process being greatly retarded. The development of the tooth continues, however,

and the little space contains more than it was designed to hold. Now at the root of the tooth is a complex, highly sensitive structure of blood vessels and nerves. It is not the pressure of the tooth on the gum which causes pain, but the back pressure of the root upon the nerves.

There are numerous cases on record where the pressure of an impacted tooth upon a nerve has caused profound mental disturbance, even insanity.

Delayed or hindered dentition may be classed as a mild form of impaction and the pressure on the underlying nerves in such a case explains the convulsions and the distressful condition into which the little sufferer subsides. If the irritation persists the nervous system becomes deranged and acts erratically, hence oftentimes convulsions occur in infants of unstable nervous equilibrium. Biting upon hard substances, especially ice, affords some relief in the first stages, but this gives pain later.

The importance of keeping the baby's teeth in good condition is usually underestimated. It is commonly supposed that the deciduous teeth, providing but temporary service as they do, exert no influence on the permanent teeth, and that their premature loss is of little importance. This, however, is far from the truth. The teeth form a frame work which regulates the size of the bones of the face, not only of the jaw but the entire face below the eyes.

If a temporary tooth is lost from the arch, the adjoining teeth move forward to close this space. The bone is not forced to its maximum development, and when the permanent teeth make their appearance, there is not room left for their appearance in the right position and they are forced out of line and crowded together. Retaining the baby teeth too long is as great a fault as the loss of one too early as they deflect the permanent tooth and force it to either the outer or inner side of the arch, if it erupts at all. It may assume a horizontal position and in that event it would become a constant source of irritation.

The odontoblastic layer from which the roots of the primary teeth is formed later becomes a destructive agency and dissolves the roots of the temporary teeth. If this layer is destroyed the roots of the teeth remain firmly fixed in the bone of the jaw and the teeth are not shed at all, irregularity of the permanent teeth results, and the appearance of the child is marred for life.

A permanent tooth may be entirely ruined from infection getting into the temporary tooth and destroying the cell of the permanent tooth; this is another reason why the temporary teeth should be well cared for. As the teeth form in the dental arch and force their way through the opposing membranes, they guide and direct bone growth and influence the form and shape of the upper and lower jaws. This in turn has produced a marked change in the shape and contour of the entire face.

It will be plain that, in the process of the evolution of the teeth, any deviation from the normal direction of growth is followed by a departure of the original plan and leaves an indelible mark on the countenance of the individual.

If the bones of the face are contracted, the floor of the nasal cavity is raised, the transverse diameter of the nasal cavity is narrowed, and the breathing space in the nose is so narrowed that you have adenoids as a result. Teeth that are irregular and crowded decay quicker than those in proper mechanical occlusion, and because they cannot be kept clean, they are also more apt to pyorrhœa.

Teeth are not separate organs, they are all more or less closely related to each other. This is shown when a tooth is lost; the adjoining teeth gradually grow closer to each other and an attempt is made to close up the opening. When a tooth is not opposed by another tooth, either above or below, it will elongate and eventually work itself out of the mouth.

There is a pressure of about two hundred and fifty pounds exerted when the lower teeth close upon the upper, this being divided between the thirty-two teeth, making only a few pounds per tooth, but when there is any malocclusion or any missing teeth, this extra pressure is at once conveyed to the teeth that occlude normally, making a greater wear and tear on the teeth that are in contact when the mouth is closed. This will cause a breaking down of the structures supporting the teeth, inviting a favorable seat for infection of the gums and deeper structures.

Pyorrhœa alveolaris at one time was thought to be due to a specific organism, known as the amœba buccalis. Today we know that this theory has been exploded and that pyorrhœa is almost entirely due to trauma caused from malocclusion.

Malocclusion not only detracts from the general facial appearance by marring the beauty of

the features, but it prevents the proper mastication of the food, which is so necessary for the proper digestion and assimilation of this food after it is taken into the stomach.

These patients rapidly become mouth breathers, allowing the air to pass into the lungs without being properly heated. It produces a drying of the mouth and infection of the tonsils, the inhalation of germs directly into the lungs, when if this air was filtered by the cillia in the nasal cavity, it would be pure. These patients often become feeding problems and they are undernourished, which makes them easy subjects for any contagious or infectious disease.

Malocclusion should be a public health problem and should be made note of in the medical inspection of school children; however, I have never heard this spoken of by people doing this work. Another reason why it should be looked for in the inspection of the school children is the importance of calling the attention of the parents to this defect early in life so that it can be corrected at this age. Malocclusion can be corrected by orthodontic treatment in a much shorter time between the fifth and eighth years, while if allowed to go until the permanent teeth appear it takes about two years, at a cost of about six hundred dollars in an average case.

There should be a much closer cooperation in this work between the pediatricians and dentists. We pediatricians should remember this in making physical examinations of our patients and see that they are advised of these defects early and it will be the means of a great saving in the lives and good health of these unfortunate individuals.

Malocclusion is a preventable disease and the point of attack is at the close of the nursing period which should not extend beyond the tenth month as so few mothers can successfully nurse their children after the tenth month. I feel confident in saying that this should be the month for weaning; to say the least, supplemental feeding should be begun.

It is unfortunate that the term temporary teeth was ever used. It has created an impression in the minds of the laity as well as a great many members of the profession, that these teeth are only of passing or temporary importance, when so much depends on them. Watch the temporary teeth, keep them clean and filled and if they are kept in position the permanent teeth will likewise come in the right position. Of equal importance is the six-year molar which comes behind the temporary teeth and is never shed. This tooth is often mistaken for a temporary tooth and is allowed to decay along with the temporary teeth. When this occurs the keystone of the arch is broken and you have the beginning of a bad occlusion. Dentists of today must reverse themselves the same as did the public health service a few years ago and go back to preventive dentistry for children. They are experts at restoring lost dentures and this is all right, but why should humanity be allowed to go through all this suffering when it can be prevented?

Some children, it is true, are hard to work for, but, on the whole, I am sure that they make very grateful patients. Temporary teeth require more attention than permanent teeth because they are in a constant state of disintegration. It is too bad, when a dentist has gone to the trouble of keeping in repair the temporary teeth, to have the neighbors tell the parents that the work he has done is useless since the teeth are only temporary, and the child never appears again for any more work. At this point the pediatrician and the public health and school nurse come in for their good work in educating these people and encouraging them to have this work done.

If you will give the study of malocclusion the time and study that you do to scoliosis and other bone deformities you will soon see that distortions of the face can be recognized on the street —the man or woman with the "pie" face, dish face, flat face, fish mouth, narrow, contracted face or hatchet-shaped face, elongated chin, retracted dental arches and long nose.

Another striking appearance is the front upper teeth protruding far over the small contracted lower jaw. We must realize that all these different forms of malocclusion can be prevented and what difference it would make in the appearance of our people, not to mention the relief from suffering and its disadvantage in social and business life.

The dentist of today should look at his work more from a general health standpoint than from a local mechanical standpoint. He should cooperate more closely with the physician, be able to recognize what may arise, and refer his patients to a man who is able to take care of them. In doing this he will be worth a great deal more to his patients, thereby laying a foundation for

what I consider the great untouched field of preventive dentistry in children—the prevention of malocclusion with its far-reaching effect on the appearance and health of children.

SYNERGISTIC ANALGESIA

C. J. Heinberg, M.D.,

Pensacola.

The use of synergistic analgesia was popularized by James T. Gwathmey of New York City, and for several years has now offered a solution to many problems especially pertaining to otolaryngology.

Researches today have a trend to find a satisfactory method of inducing and maintaining anesthesia, always bearing in mind the factor of safety. In the use of synergistic analgesia, one forward step in that direction has been taken. It is not to be supposed that this anesthetic is to supplant the other time-tested forms of anesthesia, but only to add another useful method to our armamentarium: a method of particular efficacy in operations about the head and neck, where it is of importance to have the anesthetist's mask out of a field already limited. Also, where asepsis is attempted, the elimination of the ether mask is a decidedly helpful factor.

The use of synergistic has passed far beyond the experimental stage, and in the hands of the experienced is decidedly safer than other forms of anesthesia. As safety is the watchword of anesthesia and anesthetics, the use of synergistic should be encouraged and studied. It is because of the unfamiliarity of the use and control of this anesthetic that its use has been limited in special work.

TECHNIQUE.

The technique given here is that followed by the clinic of Dr. Jos. C. Beck and Dr. Harry L. Pollock at the North Chicago Hospital, Chicago, Ill., and which we have used with excellent results.

A patient to be synergized is given a careful physical examination, and laboratory analyses. The usual preparation for operation, consisting of a cathartic the night before and enema in the morning, is given. The dosage of synergistic drugs is given according to body weight, one dose for each fifty pounds of body weight. The age, weight, general condition and mental status are taken into consideration. The average dose is morphine sulphate grains 1/8 in combination with 2 c.c. 25% c.p. magnesium sulphate. (This dose is now prepared in ampules ready for injection) and one ounce of ether and olive oil, and one dram of paraldehyde (U.S.P.). The ether, olive oil and paraldehyde are for rectal injection. For a patient weighing 135-150 pounds, three doses would be given. The morphin-magnesium sulphate combination is injected deep (intramuscularly) into the gluteal region. The doses are given at half-hour intervals, commencing three hours before time of operation. The rectal combination is started thirty minutes after the last hypodermic injection, and in order to minimize the discomfort of rectal injections, is given very slowly through a rectal tube, requiring twenty minutes for injection. As the gluteal region isn't an area of strict cleanliness, great care must be exercised in preparation of the field of injection, in order that the hypodermic needle will not carry bacteria into the gluteal muscles.

To summarize, the orders (for synergistic analgesia is given by a special nurse) for a patient weighing 150 pounds, would be as follows:

1. General preparation for operation 9 a.m. (cathartic and enema).

2. Morphine sulphate grains 1/8. Magnesium sulphate (25%) 2 c.c. (ampoule). Give deep into buttocks. Three doses—

1 at 6:00 a.m.
2 at 6:30 a.m.
3 at 7:00 a.m.

3. Ether,

Olive oil, ounces three.
Paraldehyde, drams two.

Give as retention enema, starting at 7:30 a.m. and requiring not less than twenty minutes for injection.

PART OF THE NURSE.

It has been our practice to never give synergistic unless the patient employs a special nurse. It is the nurse who supplants the anesthetist here, inducing the analgesia and carefully observing the patient for any signs of idiosyncrasies to the drugs used. The nurse must cleanse the buttock thoroughly before her injections so as to prevent gluteal abscess. She must give her rectal mixture slowly. She must know how to soothe the patient and gain his confidence. The nurse must be trained as to the danger signals and their simple remedial measures.

ANALGESIA.

The odor of paraldehyde can be detected on the patient's breath within a few minutes after the rectal administration. The ether is volatilized by the heat of the rectum and is slowly and gradually absorbed as it evaporates from the oil. The proper environment is obtained by dimming the lights and not disturbing the patient. The patient is brought to the operation with the least possible disturbance. They will often climb on the cart from their bed and then from the cart to the operating table. They are responsive to questions and the reflexes are not abolished. However, the patient has no memory of any happenings.

Crile's observations on shock are adhered to. Psychic shock is eliminated as the patient goes peacefully to sleep in bed, and never sees the operating room and its instruments. The terror of the operation, the excitement stage of ether anesthesia, and all forms of cyanosis are obviously eliminated. The blood is fully oxygenated at all times.

To the onlooker, the performance of a major procedure on a patient who is at all times cooperative, is a distinct thrill.

As each individual is a law unto himself in regard to the actions of drugs, we sometimes have patients who are not affected deeply enough by the drugs given, and therefore are not deeply enough synergized for operation. When this occurs a few inhalations of ether will have the patient completely anesthetized, and it is surprising to find just how little ether, inhaled through a mask, is needed to complete the work of the rectal injection. Especially in alcoholics and in those who have had ether on several previous occasions is this accessory anesthesia necessary. Also in incising periosteum and skin it is well to use a local injection of novocaine (1%) or other local anesthestic of choice.

The operator may start his work any time after one hour has elapsed since the rectal injection, and work as slowly and carefully as is necessary, for the patient has a measured dose of anesthetic and gets no more and no less, regardless of the duration of the operation. Thus time isn't a factor, although we agree with Dr. W. D. Haggard that the operating table isn't the proper place for a patient to convalesce. The patient remains drowsy until late afternoon, requiring no postoperative hypnotics or sedatives for that day.

COMPLICATIONS.

Occasionally a patient is too deeply narcotized. When a patient cannot be aroused and the pharyngeal reflex or corneal reflex is abolished we flush out the rectal combination with cold water enemas or return flow, allowing the patient to "wake up" to the point where we desire them for operation. Never have the symptoms been considered really dangerous, but as a matter of precaution we do not operate on a patient who is too deeply under.

Another unusual complication is gluteal abscess. This may be due to carrying infection in with the needle to a hematoma which becomes infected, or to a superficial injection of magnesium sulphate with subsequent necrosis. Incision and drainage are all that are necessary in case this happens.

We have never observed magnesium sulphate to have a deleterious effect on the respiratory center. Gwathmey advises normal salt solution intravenously for this complication.

COMMENT.

It has been long known that magnesium sulphate enhances and prolongs the action of morphine. It has no harmful effect on any body tissues, and seems to hold morphine in contact with the tissues for a protracted period of time. We are now giving all our hypnotic doses of morphine in combination with magnesium sulphate, even when local anesthesia is used and the morphine given before operation.

Most of the nausea has been eliminated with synergistic analgesia. However, manipulating the patient on the cart for movement to the operating room sometimes produces a few wretchings but never actual vomiting. This soon subsides and is probably due to the action of morphine. We have used powdered chloretone orally in an effort to eliminate this, but inasmuch as nausea is not a constant factor, it is difficult to state its value.

When the laryngologist is confronted with a patient who is "too nervous" for local operation and who simply abhors the idea of "taking ether again," synergistic analgesia is truly a "friend in need." And when patients present themselves for operation with pulmonary or cardiac complications, it is a "friend indeed."

The principle of ether in oil for rectal injection has come into use as a therapeutic measure in

the treatment of pertussis. Also it has found its place in obstetrics.

SUMMARY.

1. Synergistic analgesia is not to supplant other forms of anesthesia, but to supplement.

2. The dosage is fairly constant and technique of administration easy.

3. It has a great threshold of safety.

4. It eliminates psychic shock and haste in operative work.

5. Accessory anesthesia is sometimes necessary.

6. Complications are unusual and not dangerous.

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THE DIABETIDES*

Presentation of Cases with Discussion.

SPENCER A. FOLSOM, M.D.,

Orlando.

It is seldom that one is so fortunate as to be able to see and study, in the course of two weeks, the two diabetides side by side. Since this has happened so opportunely I am very glad to present to you for diagnosis, treatment and discussion two cases, one of diabetes insipidus or pituitary deficiency in a male child aged eleven and one of diabetes mellitus with coma in a female adult aged forty-three.

The child presented himself with the chief complaints of weakness, polydipsia and polyuria. He had been in good health up to two months previously when the above mentioned symptoms developed. His mother stated that he drank about 5-6 quarts a day and conditions were such that he could not sleep at night on account of the urgency of the nocturia and that remaining in a school room was an impossibility.

His past history, with the exception of the usual diseases of childhood, and family history, were negative, although one brother, aged nine, was regarded as a "nervous child." This younger brother, however, at no time gave any symptoms of pathology.

The mother stated that the patient was always a normal child since birth and that he was progressing very well in his school studies up to the time of his present incapacitation.

Physical examination disclosed that the patient was in good condition, weighing seventy-eight pounds, a slight anemia with hemoglobin 85 per cent (Sahli) and a chronic infection of the tonsillar tissue.

The total twenty-four fluid intake was seven liters and the urinary output was six liters. The specific gravity varied from 1.001 to 1.007, negative for sugar or other abnormal constituents and microscopically negative. Blood-sugar, fasting 12 hours, was 110 mgms. per 100 c.c. Rœntgenogram of the sella turcica was negative. The blood Wassermann was negative.

A diagnosis, in this case, was made of idiopathic diabetes insipidus or functional diabetes insipidus, or, as some choose to call it, pituitary deficiency (pseudo diabetic). He was allowed his normal diet, cautioned to use no salt but a substitute composed of sodium citrate 1 dram, sodium bromide one ounce, advised to curtail the fluid intake, removed from school and its attendant nervous fatigue and given 0.5 c.c surgical pituitrin subcutaneously daily.

Seven days from the beginning of treatment the twenty-four hours' fluid intake was reduced to one and one-half liters and the fluid output to two liters with much improvement in his general wellbeing.

In differentiating a polyuria from a pollakiuria always get a twenty-four specimen because the latter can often be mistaken for the former. So often simple frequency or pollakiuria is called polyuria.

Again let us remember that the only other common diseases with polyuria that can be regarded in a child this age are diabetes mellitus, hydronephrosis, temporary polyuria in the neurosis, Dietl's crises and cerebral tumors. Syphilis and eye-strain often cause simple frequency. None of the diseases above mentioned are characterized by polydipsia excepting diabetes mellitus and cerebral tumors affecting the pituitary body.

In discussing diabetes insipidus it is important to remember that it is most common in growing persons between five and twenty-five years of age, males usually, may be congenital and that a hereditary tendency has been reported by Weil.

There are two types, the idiopathic or functional and the secondary or organic, the latter usually caused by tumors or inflammation.

*Read before the De Soto-Hardee-Highlands County Medical Society at Sebring, Dec. 14, 1926.

The causes of the functional can be listed as fright, nervous strain, exposure and alcoholic excesses. Those of the organic are a variety of cerebral lesions, especially pituitary tumors, gummata, syphilitic meningitis and trauma.

The symptoms commonly observed are weakness, nervousness, emotional states, polydipsia, polyuria with pollakiuria, headaches and sometimes epistaxis.

So far as the laboratory is concerned the findings are essentially negative in the functional. However, in the organic type low basal metabolic rates and achlorhydria are the rule.

The well-known changes in the contour of the sella as demonstrated by the Rœntgen ray, the alteration of the visual fields and the ophthalmoscopic findings demonstrate the presence of a pituitary tumor in the organic type.

It is interesting to note that the treatment of a syphilitic meningitis, although of low grade type, causing diabetes insipidus, is almost always very disappointing. Other cases of syphilitic meningitis not causing polyuria occasionally respond to treatment with tryparsamide in small doses and intraspinal and intracisternal methods of approach.

Where a tumor involves the pituitary or causes symptoms by pressure on it surgical measures in the hands of a very experienced operator are usually better.

A problem for explanation by those who are versed in elaborating theories is the occasional instance of complete recovery on the functional type after a spinal puncture.

There is some doubt today in the minds of many familiar with all the aspects of the disease as to whether it always arises from pituitary lesions alone, as basilar meningitis may be a cause, and in animals the disease has been experimentally produced by injury to the brain in the interpeduncular space and in the para-infundibular region of the hypothalamus.

If you will pardon a personal reference, I was very much interested some years ago while treating paretics by the intracistern method in a case where polyuria was apparently produced in a case after the first cistern puncture. The polyuria persisted for one week and then disappeared as suddenly as it came. Such is the mystery of the cerebrum and its coverings.

Treatment directed to the cause of diabetes insipidus has been rarely successful and we depend mainly on the use of surgical pituitary extract by the subcutaneous route. This has relieved the symptoms in most cases. Other methods in use are the oral, rectal and intranasal. The fresh gland substance is used but has no foundation for its use.

The close of the pituitrin daily is 0.5 c.c. to 2 c.c. given in one dose or divided as the case may be to suit the needs of the individual. The patients are advised to limit the fluid intake, the salt intake or are given a substitute for salt as mentioned previously.

The disease is not fatal per se, but tuberculosis and other intercurrent infections often hasten the individual to a rapid termination due no doubt to the poor resistance offered by the organism. This poor resistance can be theoretically explained by the nervous drain, so to speak, occasioned by the disease. The counterpart of this is often seen in the extreme neurotics who seem unable to effectively fight an active infection. Constant mental or nervous exhaustion thus offers a fertile field for disease because phagocytosis is feeble or not up to the standard as might be expected.

Unfortunately, the long-continued use of pituitary extract does not offer the curative result that insulin does in diabetes mellitus. It is merely a symptomatic reliever, as the use of pituitary extract in this condition can hardly be called pure substitution therapy.

To our surprise, mystification and delight there may be spontaneous recovery or occasionally slight remissions, but what causes all this we do not know and can hardly surmise.

I think it is wise to examine all doubtful cases at frequent intervals because signs of real intracranial disease may develop in a case primarily thought to be purely functional.

The case of diabetes mellitus with coma was first seen at her home. She was in light coma, that is, could be roused with some difficulty, heavy odor of acetine on the breath, polypnea and dyspnea of the Kussmaul "air hunger type." She was given 80 units of insulin at once and forced to swallow 20 gm. glucose in orange juice one glass. Thereafter, she was given 15 gm. glucose hourly by mouth in a glass of orange juice. The insulin was continued in the dosage of 40 units in one hour, 20 units in three hours, 40 units in three hours, 20 units in three hours, 20 units in three hours and 30 units in the next three hours. There was given a total of 250 units in 12 hours. External heat in the form of blankets and hot water bottles was ordered,

liquids such as hot tea, coffee and broths were forced in the amount of 1000 c.c. every 6 hours. Digitalis and caffeine were given for the poor cardiac action. One low soap suds enema a day was given. Going into coma at about 5 o'clock one morning she was fully awake and able to converse intelligently the next morning at 8 o'clock. Such is the heritage of insulin given as by McLeod, Banting and Best.

The proper management of a threatening or developed coma should be thoroughly understood by us all and I think it is a good plan for everyone to always have some insulin handy. All cases should be hospitalized if possible, kept very quiet and warm in bed. Enemata should be used in preference to anything else as cathartics are apt to cause a diarrhea and thus increase the already present acidosis. For the shock which accompanies the coma caffeine and digitalis are indispensable. 1000 c.c. of liquids as a minimum in the form of hot tea, coffee and broths should be given routinely every 6 hours. The patient should be given an initial 20 gm. of glucose by mouth and at least 50 units of insulin. In deep coma cases the insulin and glucose may be given intravenously, the latter in the form of a 5% to 50% solution. In the home, on the other hand, 5% glucose solution may be given per rectum and the insulin subcutaneously.

All depends on the reaction of the patient when the glucose as well as the insulin may be increased or decreased. It has been suggested by Musser that the safe rule is to continue giving the glucose 15 gm. hourly and the insulin 10-40 units every three hours unless the glycosuria cleans up. As soon as the patients recover consciousness they should be started on a diet high in carbohydrate content in order to overcome the ketosis. When the urine becomes free of diacetic acid the carbohydrate is reduced and diet calculated according to the patient.

In the patient under discussion the urine did not become free of diacetic acid for three days, during which time she was given 20 gm. of glucose every three hours from 8 a.m. to 9 p.m., with a dosage of insulin divided into 20 units in the morning, ten at noon and ten at night.

On the fourth day, with the urine sugar free, a diet was calculated on a basis of an estimated weight of 110 lbs. or 50 kilos. Using the method of Woodgatt this was calculated as follows:

25 calories per kilo. necessary.
50x25 = 1250 cal. in 24 hrs. (Basal Rate.)
Protein necessary 1 gm. per kilo.
Therefore: P = 50 gm.

$$C = \frac{\text{Cal.} - 8.86\,P = 36 \text{ gm.}}{22}$$

$$F = \frac{P}{2}$$

C lb 2 = 97 gm.

Ketogenic — Antiketogenic Ratio.

$$\frac{FA}{G} = 1.5$$

$$\frac{FA}{G} = \frac{.46P \text{ lb } .90F}{C \text{ lb } .58P \text{ lb } .10F} = 1.4$$

On this diet the urine again showed sugar, indicating a poor glucose tolerance due to pancreatic fatigue, so a twenty-four-hour specimen was collected and the glucose excreted estimated quantitatively by the Benedict method. This found to be 20 gm., so the insulin dosage was increased to 60 units a day; 25 units one-half hour before breakfast, 10 on the same schedule at noon and 25 in the evening. This rendered her sugar-free and she remained so for one week.

About two to three hours after the insulin in the evening she complained of extreme nervousness, excessive perspiration, tremor and palpitation. This was hyperinsulinism and disappeared very promptly when the evening dosage was omitted.

On 35 units a day she continued to remain sugar-free in the urine and was feeling extremely well. However, a fasting blood-sugar at this time showed that a content of 280.3 mgm. per 100 c.c. was present.

As she had gained in weight and seemingly was so sensitive to insulin above a certain limit I disregarded the blood sugar and recalculated the diet on a basis of 120 pounds or 5 pounds above her gained weight. This gave a diet as follows:

P = 54 gm.
C = 39 gm.
F = 105 gm.
Calories 1350
Ketogenic — Antiketogenic Ratio 1.4

On this diet and on insulin dosage of 25 units, 15 in the morning and 10 at noon, she has continued to remain sugar-free in the urine, feels well and is gaining in weight.

You might well ask the question, what are you going to do about the blood-sugar? Frankly, I don't intend to do anything about it for at

least one to two months as long as glycosuria is not present because in this length of time she will be able to gain in weight, increase her resistance to intercurrent infections and possibly the pancreas will be rested sufficiently to tolerate more glucose or the organism be able to stand more insulin without shock.

I realize and appreciate the importance and significance of high blood-sugars, but I also believe that we should temper treatment with reason. We can become too scientific for our patients in our enthusiasm to reduce blood-sugars quickly. When the patient reacts to insulin, a high blood-sugar being present and no glucosuria I believe in waiting and giving the organism time to recuperate. One does not accomplish much by beating a tired horse.

The history obtained from this patient showed that the duration of the disease was one year and three months and that she had lost 79 pounds in weight. She first presented the symptoms of polydipsia, polyuria and pollakiuria, was diagnosed as diabetes mellitus, but had never been given a written diet calculated to her needs. In short, this is the first time she has ever been sugar-free in the urine and I am wondering, as well as you might, how she lasted this length of time.

As far as diet was concerned she was merely told to eat so much of this or so much of that, verbally, and for the last three months had been taking one of the too numerous pancreas compounds by mouth. This according to the claims of the manufacturer was supposed to eliminate the necessity and bother of taking insulin. What crimes are committed in the name of medicine! Personally, I think that this is nothing short of criminal, as pancreas compounds by mouth or subcutaneously have had no evidence to warrant their use whether empirically or scientifically. It has often been said, and truly so, that the American public believes what it reads. We of the profession are human and also subject to the same errors as the laity. We should believe less of manufacturer's claims and read more in standard texts and articles. This woman was lulled into a sense of false security because she thought she was taking insulin by mouth. The result was, as it always will be under similar circumstances, coma or death!

In conclusion I wish to state that each case of coma is a law unto itself and is enough to tax one to the utmost, but by following some sort of routine of treatment as outlined much can be accomplished and lives saved. "Thought is hard and judgment is difficult, but treatment after thought is profitable."

VINCENT'S INFECTION

J. C. Inman, Jr., M.D.,
Chattahoochee.

The condition known as Vincent's Angina is a term long known to medical literature. It is not extensively described, and from the literature one gets the impression that it is of little significance and a rare condition. However, since January 1st we have observed at the Florida State Hospital 42 cases, and for this reason we believe it not a rare condition, and not always a trivial affair.

The term "Vincent's Angina" was originally used to indicate an infection of the tonsils by Vincent's spirillum and fusiform bacillus, whose symbiotic and anærobic characteristics are well known, and gradually spread to the mouth and especially the gums. However, it is now known that it may begin primarily on the tonsils, gums or pharyngeal membrane, also that either point may be involved for several days, and sometimes weeks, before the others are involved. In our series of cases the majority of lesions seem to involve the gums primarily. The disease seems to occur most frequently in neglected mouths, especially in women and cigarette smokers. Syphilitics are said to be very susceptible, but its appearance in no way implies the presence of lues. The onset usually begins with a painful inflammation along the gingival tissue, especially between the teeth. This is characterized by a sudden onset and by the formation of a grayish slough which sometimes extends rapidly and at other times slowly. The speed seems to depend upon the general health of the individual. The breath has a characteristic foul odor. Gums retracted, tender and bleed easy, loss of appetite. The soreness of the gums in advanced cases renders it almost impossible for the patient to take solid food. Sloughs and ulceration, especially involving the periphery of the tonsil. Tongue often covered with a thick fur, and at times tender and painful. Tonsils at times present a pseudo-membranous appearance very similar to diphtheria. Constant drooling of saliva in advanced cases. Mental depression a

constant, common and distressing complaint.

At late stages in the disease there is frequently a distinct ulceration, the ulcers having defined margin and "punched out" appearance so that clinically they have been erroneously diagnosed as syphilis.

Apart from the localized pain the symptoms are usually mild, but occasionally systemic disturbances have been observed. The diagnosis of Vincent's infection is usually very easy. A smear taken from the involved area and stained with Loeffler's methylene-blue, together with the local symptoms is diagnostic. In cases where both the Vincent's organism and diphtheroid bacilli are found, a culture should be made on Loeffler's blood again; in case of Vincent's infection the culture, of course, is always negative.

By some observers the organisms are looked upon as secondary invaders; opposed to this, however, are the facts that the organisms are found only infrequently in the clean and healthy mouth.

The question as to treatment of Vincent's infection has not been definitely settled. Numerous local applications have been used, analine dyes, silver nitrate, arsenical preparations, 5% neo-arsphenamine and as high as 20% solution of neo-arsphenamine have been used without success. Miller applies powdered arsphenamine to the areas and reports favorable results.

Neo-arsphenamine and arsphenamine have been used quite extensively intravenously with very good results, but the symptoms are not relieved under 4 to 6 weeks and arsenicals are not by any means specific in all cases. Tonsillectomy has been reported as an effectual and permanent cure; however, we have observed several cases where the tonsils had been removd.

Recently we have been using tartar emetic ¾ gr. every two or three days intravenously, and tincture ferri chloride locally as an astringent three times a day. With this treatment the majority of cases are symptom-free in about one week's duration, and practically all are symptom-free in two weeks' duration. In case ulcers have developed before the case comes under observation, they are best treated by touching the edges of the ulcers with powdered copper sulphate. All cases we believe should be treated one to two weeks after the symptoms disappear, depending, of course, upon the duration and severity of the case.

The prognosis is usually favorable though it may terminate fatally; the patient may become so worn out by loss of sleep, worry, improper and insufficient food as to fall an easy prey to some intercurrent infection. The earlier treatment is begun and the more intensively it is carried out the better the prognosis. Relapses are more difficult to heal than the original lesion.

In Memoriam

Joseph Tolbert Sandlin, M. D.

Dr. Joseph Tolbert Sandlin died at his home in Tampa November 15th, 1926.

He was born near Birmingham, Alabama, July 4th, 1880, educated in the common schools of Alabama, but went to Arkansas while he was still a boy, where he worked until he entered the Medical Department of the University of Arkansas, from which college he graduated in 1911.

About six years ago he came to Tampa and entered X-ray work, with offices in the Stovall building. He was a member of the Hillsborough County Medical Society, the Masonic Lodge, the American Legion and the First Christian Church of Tampa.

Dr. Sandlin was loved by all who knew him and was recognized as an example of Christian manhood, possessing the kindest and most charitable disposition.

He is survived by his wife, Mrs. Louetta Sandlin of Tampa, and four daughters.

Resolutions Adopted by the Hillsborough County Medical Society.

Whereas, on November 15th, 1926, the Hillsborough County Medical Society lost a member in the death of Dr. J. T. Sandlin, and

Whereas, Dr. Sandlin was loyal to his profession, sympathetic toward his patients, charitable toward the poor, always assuming his part of any work and aiding in any good cause, and

Whereas, his presence will be missed by his professional associates and fellow-members of this society,

Be it resolved, That the members of Hillsborough County Medical Society express their grief in the loss of Dr. Sandlin and sympathy for his family. That a copy of these resolutions be spread on the minutes of the Society, and one sent to his family.

THE HONOR GUEST OF THE NEXT ANNUAL CONVENTION



DR. LEWELLYS F. BARKER.

The members of the Florida Medical Association who attend the next annual session at West Palm Beach have a very great treat in store for them in the address of Dr. Lewellys F. Barker, of Baltimore, who will be the honor guest of the Association this year.

It is unusual and indeed fortunate for us that a man so illustrious, whose fame is international and whose time is so fully occupied, should accept our invitation and come all the way to Florida to address us.

The writer has information that Dr. Barker has declined many similar invitations at about this time, but because he has such a kindly feeling toward Florida and has so many friends in the state he accepted our invitation with pleasure.

Dr. Barker has not yet announced his subject, but that is not so important, as he will make any subject on which he talks very interesting. What is important is the fact he is going to address us.

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ARTICLES OF INCORPORATION,

FLORIDA MEDICAL ASSOCIATION.

At the last annual meeting of the Florida Medical Association, the House of Delegates instructed the officers of the Florida Medical Association to proceed with the articles of incorporation. This work has just recently been completed, and is undoubtedly a step forward in our organization. Organized medicine has always been the target of unjust lawsuits perpetrated by the irregular element and the present articles of incorporation will avoid the individual liability of our members. The following articles of incorporation were approved on the 13th of December by Judge Daniel Simmons, judge of the circuit court, Duval County, and were recorded on that date in the public records of the same county:

In the Circuit Court in and for
Duval County, Florida.

In Re: Incorporation of
Florida Medical Association, Inc.

To One of the Judges of the Above Named Court:

We, the undersigned, hereby associate ourselves together for the purpose of becoming a corporation, not for profit, under the laws of the state of Florida and do hereby certify that we have become such corporation under and pursuant to the following charter:

ARTICLE I.

The name of the corporation is FLORIDA MEDICAL ASSOCIATION, INC., and the place where its principal place of business is located is Jacksonville, Duval County, State of Florida.

ARTICLE II.

The general nature of the object of the corporation is to promote the science and art of medicine and the betterment of public health.

ARTICLE III.

The qualifications of each member of this corporation shall conform to the qualifications prescribed by that component society which has a charter from this corporation in the territory or boundaries of which such member resides. Any applicant for admission into this corporation shall be admitted into membership upon the certification by the secretary of any component county society that he is a member in good standing of such society, and upon the payment to the treasurer of this corporation of the current annual dues of the corporation.

ARTICLE IV.

The term for which this corporation is to exist is perpetual.

ARTICLE V.

The names and residences of the subscribers of this charter are as follows:

H. Mason Smith, M.D.,
2602 Sunset Drive, Tampa, Fla.
Shaler Richardson, M.D.,
210 Talbot Ave., Jacksonville, Fla.
Gerry R. Holden, M.D.,
205 Goodwin, Jacksonville, Fla.
C. D. Christ, M.D.,
508 So. Orange Ave., Orlando, Fla.
Sheldon Stringer, M.D.,
801 South Boulevard, Tampa, Fla.

ARTICLE VI.

The affairs of the corporation shall be managed by the executive committee of the corporation. The executive committee of the corporation shall be elected or appointed at the time and in the manner prescribed in the Constitution and By-Laws of the corporation.

ARTICLE VII.

The names of the officers who are to manage all the affairs of this corporation until the first election or appointment of officers under this charter, are as follows:

H. Mason Smith, M.D.
Shaler Richardson, M.D.
Gerry R. Holden, M.D.
C. D. Christ, M. D.
Sheldon Stringer, M.D.

ARTICLE VIII.

The by-laws of this corporation shall be made, altered or rescinded by majority vote of the House of Delegates, in the manner prescribed by the By-Laws.

The Constitution of the corporation shall be adopted by a majority vote of the delegates registered at the first annual session of the House of Delegates. The Constitution of the corporation may be altered, amended or rescinded by majority vote of the delegates registered in the manner prescribed by the Constitution.

ARTICLE IX.

The highest amount of indebtedness or liability to which the corporation may at any time subject itself shall be five million dollars ($5,000,000.00), provided, however, that the highest amount of indebtedness or liability of the corporation shall never be greater than two-thirds of the value of the property of the corporation.

ARTICLE X.

The amount and value of the real estate which the corporation may hold, subject always to the approval of one of the Judges of the Circuit Court in and for Duval County, Florida, shall be five million dollars ($5,000,000.00).

ARTICLE XI.

The corporation shall have the power, subject to the laws of the state of Florida affecting corporations not for profit, to buy, hold, own, work, develop, improve, divide, sub-divide, process, sell, convey, lease, mortgage, pledge, exchange and otherwise deal in and dispose of property of all kinds, real, personal and mixed, including stocks, bonds and securities, issued or created by any other corporation in any other state or country, and whether now or hereafter organized, and including rights, easements and incorporeal hereditaments appurtenant thereto and including patents, patent rights and processes, water rights, permits, privileges, franchises, licenses, sewer systems, water power and waterworks; plants for the generation, distribution and supply of electricity, gas, steam and other agencies for light and heat and other purposes to which the same may be adapted; to purchase, establish, operate and publish, or cause to be published, journals, books, bulletins, and advertising matter; to build, construct, maintain and operate any of the properties above mentioned, and while owner of any property, to exercise all the rights, powers, and privileges of ownership to the same extent as natural persons might do, including the right to vote the stock of other corporations owned by it; to borrow money and secure the same and monies otherwise owing, by mortgages, debentures, bonds, deeds, notes or other obligations therefor; to enter into, make, perform and carry out contracts of every kind for any lawful purpose; to draw, make, accept, endorse, execute and issue promissory notes, drafts, bills of exchange, warrants, debentures and other negotiable or transferable instruments; to carry on any or all of its operations or businesses and to promote its objects within the state of Florida or elsewhere without restriction as to place; to have, use, exercise, and enjoy all the general powers of like corporations not for profit and to do and perform all such other things and acts as may be necessary or expedient in carrying on any of the businesses or acts above named.

The intention is that none of the objects and powers hereinabove specified and clauses contained in this article, except where otherwise specified in this article, shall be in any wise limited or restricted by reference to, or inference from the terms of any other objects, powers, or clauses of this article or any other article in this charter, but that the objects and powers specified in each of the clauses in this article shall be regarded as independent objects and powers.

ARTICLE XII.

This corporation reserves the right to amend, alter, change or repeal any provisions contained in this charter in the manner now or hereafter prescribed by law

and all rights conferred on members in this corporation are granted subject to this reservation.

In witness whereof, we, the undersigned, subscribing incorporators, have hereunto set our hands and seals this 28th day of October, A. D., 1926, for the purpose of forming this corporation, not for profit, under the laws of the state of Florida.

H. Mason Smith, M.D., (SEAL)
Shaler Richardson, M.D., (SEAL)
Gerry R. Holden, M.D., (SEAL)
C. D. Christ, M.D., (SEAL)
Sheldon Stringer, M.D. (SEAL)

STATE OF FLORIDA, }
County of Duval } ss.

Before me personally appeared Shaler Richardson, to me well known and known to me to be one of the individuals prescribed in and who executed the foregoing charter, and acknowledged before me that he executed the same for the purpose therein expressed.

Shaler Richardson.

Witness my hand and official seal this 28th day of October, A. D. 1926.

S. G. Thompson,
Notary Public in and for the County of Duval, State of Florida.
My commission expires April 2, 1928.

STATE OF FLORIDA, }
County of Duval } ss.

Before me personally appeared Shaler Richardson, who being by me first duly sworn, deposes and says under oath, that he is one of the subscribing incorporators of the foregoing charter and that he has acknowledged that he executed the foregoing charter as one of the subscribing incorporators thereof before S. G. Thompson, a notary public, authorized under the laws of Florida to take acknowledgments of deeds, and that the foregoing charter is intended in good faith to carry out the purposes and objects set forth therein.

Shaler Richardson.

Sworn to and subscribed before me this 28th day of October, A. D. 1926.

S. G. Thompson,
Notary Public in and for the County of Duval, State of Florida.

My commission expires April 2, 1928.

ORDER.

The above proposed charter, having been presented to me, I find that the same is in proper form and for an object authorized by the laws of the State of Florida, and I approve said charter and hereby endorse my approval thereon.

Thus done and ordered, in chambers at Jacksonville, Florida, this 13th day of December, A. D., 1926.

Daniel Simmons,
Judge of Circuit Court in and for Duval County, Florida.

(Seal) No. 164-215-A

Filed Dec. 13, 1926,
at 10.21 o'clock A. M.

Recorded in the public records of Duval County, Florida, in the book and page noted above.

Frank Brown, Clerk Circuit Court,
By P. H. Arms, Deputy Clerk.

$100,000 OFFERED FOR CONQUEST OF CANCER

Two prizes of $50,000 each have been offered by William Lawrence Saunders of New York for discoveries of the causation, prevention and cure of cancer. The offer was made on December 15, 1926, and will stand for three years. The donor expects to renew it, if necessary.

Mr. Saunders is Chairman of the Board of Directors of the Ingersoll-Rand Company, Director of the Federal Reserve Bank of New York and President of the United Engineering Company.

The decision upon which the awards will be made is to be reached by the American Society for the Control of Cancer and approved by the American Medical Association and the American College of Surgeons.

It is Mr. Saunders' idea that discoveries are not always made by experts and that "through the lure of a reward this serious problem might be solved through the genius of a lay mind, by chemists or through unorganized medical sources."

The offer of Mr. Saunders to the American Society for the Control of Cancer has not yet been formally acted upon by the Society, and it is impossible to say at this time what rules other than those proposed by Mr. Saunders will control the decisions. Information as to how persons who wish to present their discoveries for consideration should proceed will be announced later.

Mr. Saunders made his offer known through a letter to Dr. C. N. B. Camac of New York under date of December 13, 1926, and read by Dr. Camac at a dinner given in the interests of the American Society for the Control of Cancer by President Nicholas Murray Butler of Columbia University and Honorable Charles Evans Hughes.

New York, December 13, 1926.

Dr. C. N. B. Camac,
76 East 56th Street,
New York.

Dear Dr. Camac:

I regret that because of a previous engagement, which I cannot well forego, I shall be unable to accept your kind invitation to be present at the dinner on the 15th inst. in the interest of the American Society for the Control of Cancer.

May I ask you to represent me on this occasion by making the following statement?

I will give Fifty Thousand Dollars ($50,000.00) to any person or group of persons who may discover what human cancer is and how it can positively be prevented.

I will give Fifty Thousand Dollars ($50,000.00), to any person or group of persons who may discover an absolute cure for human cancer.

The entire sum, that is, One Hundred Thousand Dollars ($100,000.00), may be given to the same person or group of persons.

The decision upon which these awards shall be made is to be determined by the American Society for the Control of Cancer and approved by the American Medical Association and the American College of Surgeons.

This proposition shall expire at the end of three (3) years from the date of this letter, unless it is further extended by me. This I hope and expect to do.

What I have in mind is this: Discoveries are not always made by experts. Physicians, like business men, are not always the best research workers. Through the lure of a reward this serious problem might be solved through the genius of a lay mind, by chemists or through unknown and unorganized medical sources.

Yellow fever, for instance, has been destroyed through the research work of three obscure Army surgeons—Reed, Lazier and Carroll. As far as I know, no cure for yellow fever has been found, nor is a cure necessary so long as we now know how to control and prevent the disease.

This letter gives only the outline of this proposition, the details of which might be drawn up by the American Society for the Control of Cancer, or by such other persons as they may select.

Very truly yours,

(Signed) William Lawrence Saunders.

FLORIDA'S NEW HOSPITALS

In this issue of the *Journal* there appear written and picture descriptions of hospitals that are being constructed in Volusia and Marion counties. Both of these structures are to be the latest word in hospital construction and will be manned by men of the highest professional ability. These counties are to be congratulated on their enterprise in erecting such hospital plants. There are other counties in Florida that are sorely in need of adequate hospital facilities and it is hoped it will not be many years before Florida will have well-equipped hospitals in every population centre.

NEWS ITEMS

The following interesting program was given at the quarterly meeting of the Second District County Medical Society at Quincy, December 8th, at 3:30 p. m.:

1. A lecture on Fracture of Upper Extremity—Dr. J. Knox Simpson, Jacksonville.
2. Blood Stream Infection—Dr. J. Q. Folmar, Chattahoochee.
 Discussion led by Dr. J. C. Inman, Jr., Chattahoochee, and Dr. J. C. Davis, Quincy.
3. "Was It Primary Carcinoma of the Liver?"—Dr. R. F. Godard, of Quincy.
 Discussion by Drs. J. Kent Johnston and B. A. Wilkinson, of Tallahassee.
4. Stricture of the Female Urethra—Case Report by Dr. H. E. Palmer, Tallahassee.
 Discussion by Dr. J. C. Davis, of Quincy, and Dr. F. C. Moor, of Tallahassee.

Immediately after the reading of the papers the members and guests adjourned to the Quincy Hotel to partake of a turkey dinner.

The Second District County Medical Society is certainly to be congratulated on the excellent programs they are having and some of our county societies would do well to model their programs after this society.

* * *

The Columbia County Medical Society, on December 14th, were dinner hosts to the doctors of Hamilton, Madison and Suwannee counties. The meeting was held at the Blanche Hotel, Lake City. Dr. H. Mason Smith was the principal speaker of the evening. The Columbia-Hamilton-Madison-Suwannee County Medical Society was organized and the following officers were elected: President, Dr. E. Long, Madison; first vice-president, Dr. T. S. Anderson, Live Oak; second vice-president, Dr. W. B. McRae, Jasper; secretary-treasurer, Dr. L. J. Arnold, Lake City. The following were present: Drs. A. E. Blalock, Madison; T. S. Anderson, Live Oak; State President H. Mason Smith, Tampa; J. P. Kinsey, Pinetta; E. Long, Madison; W. B. McRae, and J. R. Bruce, Jasper; H. Marshall Taylor, R. N. Green and State Secretary-Treasurer Shaler Richardson, of Jacksonville; R. A. Barnett and D. N. Cone, White Springs; P. C. Farnell and Eleanor A. Harthill, Lake City; L. M. Anderson, P. B. Harkness, E. A. Welch, L. J. Arnold, W. M. Ives, John D. Gables, I. A. Black, Howard Caldwell and James H. Dyle, Lake City, and C. M. Griffith, U. S. Veterans' Bureau, Washington, D. C.

* * *

At the last meeting of the Palm Beach County Medical Society, the following officers were elected for the year 1927: President, Geo. M. Dawson, M.D., West Palm Beach; vice-president, V. D. Stone, M.D., West Palm Beach; secretary, W. W. George, M.D., West Palm Beach; treasurer, G. W. Heath, M. D., West Palm Beach.

The Atlantic Coast Line Railroad surgeons will hold their annual meeting on January 20-21, at the Princess Martha Hotel, St. Petersburg. Dr. G. C. Tillman of Gainesville is president, and Dr. Harry Ainsworth of Thomasville, Ga., secretary.

* * *

The staff of the Pensacola Hospital met December 21st, at the hospital. The following officers were elected to serve during 1927: Dr. J. H. Pierpont, president; Dr. M. A. Lischkoff, vice-president; Dr. J. M. Hoffman, secretary. Drs. C. C. Webb and W. C. Payne serve with the above officers as executive committee.

* * *

Dr. J. S. Helms of Tampa has just returned from a trip to New York, Rochester, Minn., Cleveland, Ohio, and Montreal, Canada. Dr. Helms was elected on the Board of Governors of the American College of Surgeons for the fourth consecutive time.

* * *

Dr. Mary Knott Bazemore and little daughter returned to their home at West Palm Beach recently. Dr. Bazemore has been visiting her parents, Mr. and Mrs. W. V. Knott, at the Florida State Hospital.

* * *

Dr. W. P. McKee of Eustis spent the Christmas holidays at Pinehurst, N. C.

* * *

At the last meeting of the Hillsborough County Medical Society the following officers were elected for the year 1927: President, Dr. C. R. Marney, Tampa; vice-president, Dr. D. D. Martin, Tampa; secretary-treasurer, Dr. B. W. Lowry, Tampa.

* * *

At the next annual meeting of the state association, it is contemplated to have a conference of the secretaries of the component county medical societies, together with the secretary-editor and business manager of the state association. It is believed that such a conference will be a great assistance to all concerned.

* * *

Dr. W. C. Williams, Jr., of Delray, spent Christmas at his former home in Cochran, Ga.

At the December meeting of the Marion County Medical Society, the following officers were elected for the year 1927: President, Dr. Albert H. Freeman, Ocala; vice-president, Dr. H. W. Henry, Ocala; secretary-treasurer, Dr. J. L. Chalker, Ocala. Resolutions were passed at this meeting requiring each member to attend at least two meetings each year in addition to paying dues in order to keep his membership in good standing.

* * *

The regular meeting of the Escambia County Medical Society was held December 14th at the State Board of Health laboratory. The following officers were elected to serve during the ensuing year: Dr. J. S. Turberville, Century, president; Dr. J. H. Bickerstaff, Pensacola, vice-president; Dr. J. M. Hoffman, Pensacola, secretary-treasurer.

* * *

An appeal has been made by Hon. M. C. Garrett, representative from Okaloosa County for the 1925 session, for a physician to locate at Baker, Florida.

* * *

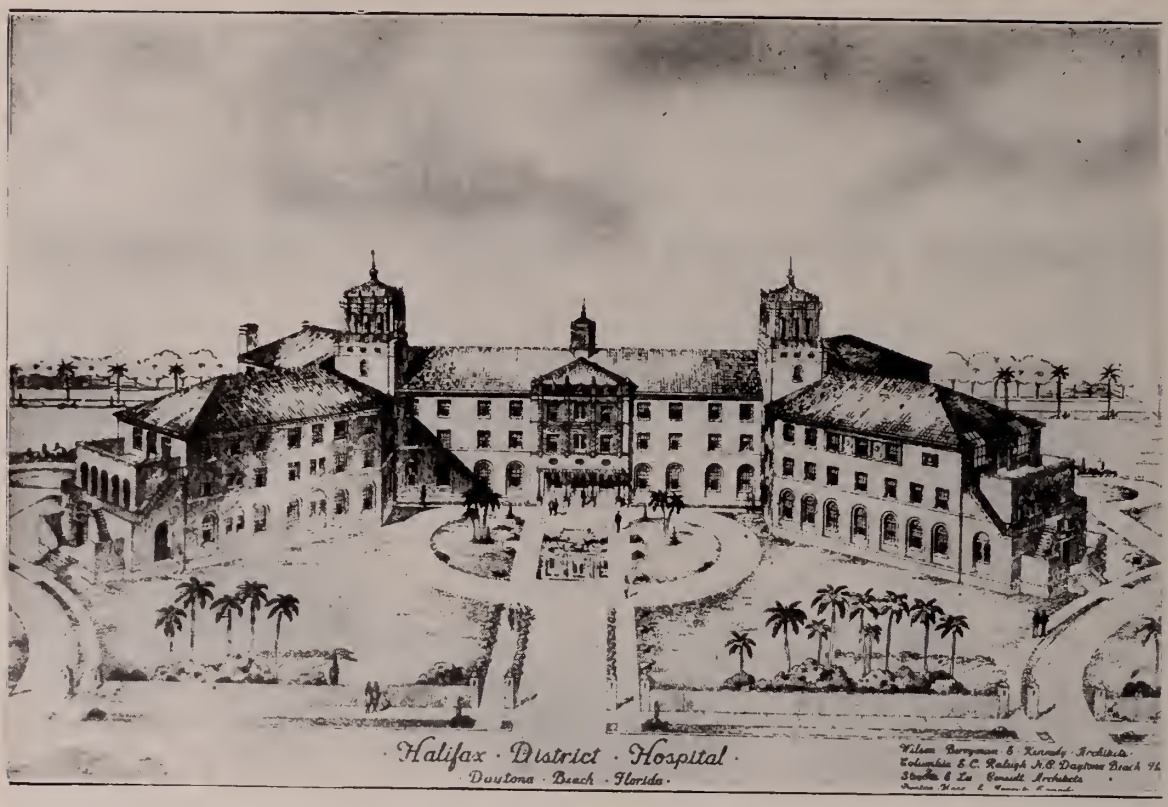
The Volusia County Medical Society, at their last annual meeting, elected the following officers: President, Dr. Davis Forster, New Smyrna; vice-president, Dr. L. W. Glatzau, DeLand; secretary-treasurer, Dr. R. L. Miller, Daytona Beach. Dinner was served following the meeting.

* * *

At the December meeting of the Broward County Medical Society, the following officers were elected for the year 1927: President, Dr. H. O. Walker, Hollywood; vice-president, Dr. J. O. Stranahan, Ft. Lauderdale; secretary, Dr. L. F. Robinson, Ft. Lauderdale.

* * *

The Dade County Medical Society, at their last monthly meeting, elected the following officers to serve for the ensuing year: President, Dr. R. C. Woodard, Miami; vice-president, Dr. J. A. Simmons, Miami; secretary-treasurer, Dr. G. Raap, Miami.



HALIFAX DISTRICT HOSPITAL

Daytona Beach.

In spite of the fact that the Halifax Hospital district commissioners decided, after letting the contract, to face the new hospital to the west instead of to the east, as originally planned, work on the new structure is progressing satisfactorily and according to schedule plans.

The plans and specifications for the building were drawn by Wilson, Berryman & Kennedy of Columbia, S. C., consulting with Stevens & Lee, architects of Boston, Mass. Contract for construction was awarded to the Southern Ferro-Concrete Co. of Atlanta, for $535,000.

The plan of the building calls for a main body and four wings extending from the main body in a double Y, so that every room in the building will face the outside or the open court. The hospital will have a capacity of 125 beds, of which about 80 will be in private rooms having private or connecting bath; the remaining 45 beds will be in wards containing from two to six beds. Each ward bed will be in a cubicle, assuring privacy but allowing easy nurse supervision.

The main entrance, lobby, waiting rooms, administrative offices, library, board and staff rooms, and laboratory will be located in the center section of the first floor: X-ray rooms are at one end and are planned sufficiently large to take care of future enlargement. One wing will be devoted entirely to an outpatient department and will have its own separate waiting and record rooms, clinic and examination rooms for general and special cases. Another wing will be for reception and discharge of patients. It will contain an emergency operating room and emergency beds. One of the back wings will have laundry and boiler rooms and refrigerating machinery of the cold storage plant.

On the second floor will be the maternity department with operating and delivery rooms, private rooms, and women's wards. One of the rear wings will be taken up entirely by a large, well-appointed kitchen, with a bakery and cold storage. Adjoining the kitchen are the dining rooms for hospital help and nurses. One wing on this floor will be used as a sanitarium.

The main operating rooms will be located on the third floor and will be modern throughout. This floor will have, besides private rooms, the men's and children's wards.

Members of the hospital commission are: F. J. Niver, chairman; Don P. Shockney, Henry W. Haynes, Col. Walter R. Weiser and George N. Rigby, mayor of Ormond.



- MUNROE MEMORIAL HOSPITAL - OCALA FLORIDA -

NEW MUNROE MEMORIAL HOSPITAL

Ocala.

Contract for the erection of the new Munroe Memorial Hospital at a total cost of $101,575 was awarded at a recent meeting of the City Council of Ocala. There is still available approximately $70,000 for the equipment of the institution. The City of Ocala and County of Marion are sharing the expenses of construction jointly. In addition to the above the city owns five acres of land at the site of the building, a thirty-five-bed hospital building, which is to be converted and furnished as a modern nurses' home and training school, a modern laundry building, which is being reequipped to serve the new hospital.

The new building as designed by Mr. F. J. Uezzell of Ocala has a frontage of 134 feet by 34 feet, and a rear wing 48 feet by 34 feet, with a total capacity of 90 beds and will be three stories in height, of fireproof construction, with exterior walls and corridor bearing walls of solid masonry construction, brick and clay tile all floors, stairways, ceiling and roof, including finished floors and partitions of fireproofing material, the doors and windows only of wood. The exterior has been designed in brick with cast stone trim.

The main entrance lobby is located directly in the center of the first story and adjacent thereto is the large waiting room, with its own private telephone booth, magazine storage, and toilet. Located at the left of the lobby are the administration quarters, board room and drug room, which is at all times under the direct supervision of the superintendent. Across the corridor and directly opposite the administration quarters is the receiving ward conveniently placed adjacent to the elevator. The morgue is also located in this section and directly opposite the board room on this floor is the library with basement boiler room below the same.

A porte cochere entrance is provided at the end of the building which will be known as the doctor's entrance. The opposite end of this wing includes nurses' and private dining room, kitchen, dietitian's room and service porch.

The rear wing of this floor consists of two large wards, together with their utility rooms, diet kitchen, nurses' station and solariums with a total bed capacity of sixteen.

The second floor consists of 19 private rooms, two four-bed wards and four large solariums with an additional bed capacity of 24, together with nurses' station, diet kitchen, utility rooms, private and public bath rooms, locker storage, blanket-warming closet and linen rooms.

The northeast end of the third floor includes the operating department and consists of a main operating room, sterilizer and nurses' work room, delivery room, doctor's dressing room, anesthetic room, laboratory, eye, ear, nose and throat department, cystoscopic room, and X-ray room. Nine private bedrooms are provided on this floor adjacent to the solarium. The nurses' station and infants' ward completing the front wing. The rear wing on this floor includes two wards and solarium with a capacity of 16 beds, utility rooms and diet kitchen.

ANNUAL CONVENTION OF AMERICAN COLLEGE OF PHYSICIANS TO BE HELD AT CLEVELAND, OHIO, FEBRUARY 21-25, 1927.

Announcement is made that The American College of Physicians will hold its Eleventh Annual Clinical Session in Cleveland, Ohio, February 21-25, 1927. Dr. Alfred Stengel of Philadelphia is president of the College and Dr. John Phillips of Cleveland is the chairman of the Program Committee. The program will be of unusual interest to internists (including neurologists, pediatrists, roentgenologists, pathologists, dermatologists, psychiatrists and others engaged in the field of internal medicine). The Cleveland hospitals and the Western Reserve University will cooperate with the College in the presentation of the program. These programs constitute each year a post-graduate week on internal medicine of outstanding merit.

During the mornings there will be clinics and demonstrations at the various hospitals and in the laboratories of the Western Reserve University; during the afternoons papers on various medical topics will be delivered by local members of the professions and by members of the College from other parts of the United States and Canada; during the evenings, there will be formal addresses by distinguished guests, American or foreign, and by the president or other representatives of the College.

The American College of Physicians is a national organization in which internists may find a common meeting ground for discussion of the special problems that concern them and through which the interests of internal medicine may have proper representation. Membership in this organization is limited to those in the field of internal medicine. While it is not a limited national society of specialists (mostly prominent medical teachers), it is not coordinal with large national or sectional organizations of physicians requiring no special professional qualifications. Its standards are high and many men of distinction in the profession are numbered among its members.

An invitation has been extended by the College to all qualified physicians and laboratory workers to attend the Cleveland Clinical Session. An attendance in excess of fifteen hundred is anticipated.

ADVERTISERS' NOTES

PITUITARY EXTRACTS.

Competition may be the life of trade, but it develops some bizarre contrasts. There is competition in the manufacture of pituitary extracts, and the consequence is that the size of the required dose has been, so to speak, "in the air," one brand being several times as active as another. This situation has at last been remedied by the adoption of an official standard (U.S.P. X), but questions of purity and stability remain to be solved by the manufacturers.

In passing, we may remark that the standard adopted by the U.S.P., and seconded by the Geneva conference of the League of Nations, is the same as that which has long been applied by the house of Parke, Davis & Co., whose product, Pituitrin, is so well known.

For further particulars in regard to Pituitrin the reader is referred to the advertisement in this issue entitled "Are All Pituitary Extracts Alike?"

It is with pleasure that the Journal calls attention to the advertisement of the Holman-La-Roche Chemical Works of New York City, which appears for the first time in these pages. This company, which is one of the largest of eastern pharmaceutical houses, has twenty-five or thirty council-passed products, and is to be highly recommended. It is believed that the physicians of this state will give the firm's products and representatives a cordial reception.

The "Motion Picture Course in Proctology" offers a unique opportunity for
INTENSIVE POST GRADUATE STUDY OF RECTAL DISEASES
For particulars write: J. F. MONTAGUE, M.D., F.A.C.S., 30 East 40th St., New York, N. Y.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

		MEETINGS				Dues Paid.
County Society	Secretary	Date	Time	Place	Luncheon?	
Alachua	W. Lassiter, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Bay	J. M. Nixon, M.D., Panama City.					
Bradford	Seeber King, M.D., Lake Butler.					
Brevard	R. D. Ferguson, M.D., Titusville.	Varies		Varies		
Broward	Leigh F. Robinson, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Commerce	No.	
Columbia-Hamilton-Madison-Suwannee....	L. J. Arnold, M.D., Lake City.	2nd Monday.	7:30 P.M.	Chamber of Commerce	No.	
Dade	G. Raap, M.D., Miami.	1st Friday	8:30 P.M.	Miami City Club	Occasionally.	
DeSoto-Hardee-Highlands ...	I. W. Chandler, M.D., Avon Park.		8:00 P.M.	Varies	No.	
Duval	Louie Limbaugh, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Arnold-Edw. Auditorium	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	
Hillsboro	B. W. Lowry, M.D., Tampa.	1st and 3rd Tuesdays	8:00 P.M.	City Hall	No.	
Jackson	R. L. Kennedy, M.D., Malone.	2nd Tuesday	3:00 P.M.	Marianna	No.	
Lake	S. C. Colley, M.D., Tavares.	2nd Monday	12:30 P.M.	Biltavern Hotel	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson.....	F. Clifton Moor, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Manatee	J. M. Davis, M.D., Bradenton.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Harrington Hotel	Yes.	
Monroe	G. R. Plummer, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	M. M. Andrews, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach ...	W. W. George, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Monterey Hotel	Yes.	
Pasco-Hernando-Citrus.....	T. F. Jackson, M.D., Dade City.	2nd Tuesday	8:00 P.M.	Varies	Yes.	
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every other Friday	8:00 P.M.	Fla. Art School	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
St. Johns	I. M. Hay, M.D., St. Augustine.	3rd Monday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeechobee-Indian River-Martin	G. C. Hardie, M.D., Ft. Pierce.					
Sarasota	F. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	Chas. Park, M.D., Sanford.					
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	R. J. Greene, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	
Volusia	R. L. Miller, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	D. H. Simmons, M.D., DeFuniak Springs.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	

NOTE—(Secretaries: Please submit information to complete the above schedule.)

B-D PRODUCTS

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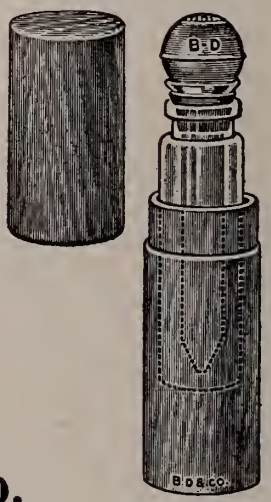
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Have you prescribed the Asepto Syringe Outfit in any of your G-U Work? It has been adopted by the U. S. Army and U. S. Navy Medical Corps, recommended by many officers in the U. S. Public Health Service and used by leading Urologists.
The rubber bulb of the Asepto Syringe permits gentle regulation of the force of injection and eliminates backflow. A single compression of the bulb will either fill or empty the syringe and only one hand is required.
Asepto Syringes are also furnished in forty styles and sizes for irrigation, aspiration and medication.

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Old Number 172 Capitol Avenue

For Mild Mental and Nervous Diseases, Alcoholic and Drug Addictions.

Located in the central residential district of Atlanta, on street car line and 5 minutes from railway terminals.

Thirty rooms en suite or single with private lavatory, toilet, private bath.

Quiet and homelike atmosphere; refined nurses and excellent cuisine.

Every patient receives the maximum of individual attention.

Completely equipped for Physic, Hydro and Thermo Therapy; deep X-Ray Therapy if indicated.

Rates and reservations furnished on application.

GEO. S. PITCHER, M.D., Director.
W. A. GARDNER, M.D., Medical Director.



Clinic Offices and Laboratories *The Annex*

GORGAS HOTEL-HOSPITAL

Provides the comforts and luxuries of a resort hotel and the complete equipment of a modern hospital, including major and minor operating rooms; x-ray, clinical and metabolic laboratories; physiotherapy department, etc. SPECIAL DEPARTMENT OF DIETETICS.

Leased and operated by the SEALE HARRIS CLINIC FOR THE DIAGNOSIS AND TREATMENT OF INTERNAL DISEASES.

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CONTENTS

	PAGE
The Cooperation of the General Profession with the Ophthalmologist in the Treatment of Squint — *Hewitt Johnston, M.D., Orlando.*	176
Tic Douloureux — *Ralph N. Greene, M.D., Jacksonville.*	178
Intraperitoneal Rupture of the Bladder—With Report of Case — *Milton M. Coplan, M.D., Miami.*	182
Some Preliminary Remarks on the Climate of Southeastern Florida and Its Relation to Disease — *Scott R. Edwards, M.D., Miami Beach.*	185
Another Case of Situs Viscerum Transposus or Transposition of the Viscera — *Jos. S. Stewart, Jr., M.D., Miami.*	188
Report of a Case of Strangulated and Gangrenous Undescended Testicle — *F. A. Vogt, M.D., Miami.*	188
Editorials: (1) Membership Roster; (2) The Palm Beach Meeting	189
State News Items	190
Invitation to Visit the Clinics of Europe	193
Woman's Auxiliary to the Florida Medical Association	193
Advertisers' Notes	193
Membership Roster, Florida Medical Association, 1926	195

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THE COOPERATION OF THE GENERAL PROFESSION WITH THE OPHTHALMOLOGIST IN THE TREATMENT OF SQUINT*

HEWITT JOHNSTON, M.D.,

Orlando.

I bring this manuscript before you, not so much as a scientific paper, but more as a plea for a muchly neglected class of children, and a call for a closer cooperation between the general profession and the ophthalmologist in the treatment of squint, with a hope that the profession as a whole may be sufficiently interested in the future as to advise the parents and guardians of such children of the importance of placing them under the care of the ophthalmologist without delay, once the defect is discovered. Much can be done for these children if treatment is instituted while the child is young, or whenever the defect manifests itself.

The nurseryman can take the plant when young and tender, and no matter how bent and crumpled it may be, by constant and proper attention, he can mold and grow it into a shapely tree, whereas if left alone it would grow into a crooked and unsightly scrub. The orthopedist can take the young child with congenital deformities, such as dislocated hip, club foot, and numerous other bone deformities; with deformities from disease, as flaccid and paralyzed muscles, tubercular spines and joints, and with his splendid skill in the use and application of orthopedic appliances, such as braces, plaster casts and jackets, along with skillful surgical procedures, he can develop that child into an almost perfect man or woman, whereas without the orthopedist's guiding hand it would have been a human wreck.

And so it is with squint. If taken while young, and painstaking and careful treatment by the ophthalmologist is carried out over a period of years, these defective children will also receive their share of benefit, and will ever be grateful to our profession for the good received at our hands.

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, May, 1926.

Now, in order that such children may have attention at the proper time, the general profession must help to educate the people up to the point where they will know what should be done wherever such children are found. It is unfortunate that up to the present time, when medical science has made such wonderful progress, that so many children with all degrees of squint should be allowed to go along for years, in many instances all through childhood and youth, with absolutely no attention given them. And much of this neglect can be laid at the door of the doctor, and rightly so, because he fails to advise the parents, or if he does advise them, it is in such half-hearted and negative a manner that the parent is left in doubt as to what really should be done. How often do we hear the expression from the child, "Mother thought I would outgrow it," or from the mother, "The doctor said wait till he started to school and maybe he would get all right when he began to use his eyes more." Such expressions should not be heard, and would not be heard; if the doctor would give the proper advice wherever such cases come before him. Treatment is what these children need and not a false hope that they may be miraculously healed, for they do not get well without treatment, and should not be led to expect such.

The general causes of squint are as follows:

1. Amblyopia, a dimness of vision or lack of visual acuity unaccompanied with fundus lesions, generally speaking.
2. Ametropia.—Deviation from the normal refractive condition of the eye. This includes, (a) Hyperopia or farsightedness, (b) Myopia or nearsightedness, and (c) Astigmatism, in which condition the rays of light entering the eye do not focus at a common point.
3. Imbalance of the external ocular muscles.
4. Paralysis of one or more of the external ocular muscles.

We have just said that amblyopia is one cause of squint. While this is true, squint on the other hand may cause amblyopia. The squinting eye, from lack of use, fails to develop its visual powers, and thus becomes amblyopic, just as other organs fail to develop their proper functions from lack of use. With muscle imbalance the

eye naturally deviates to the side of the stronger muscle, while with muscle paralysis the eye deviates away from the paralyzed muscle.

Treatment.—I shall not go into the details and technic of treatment, but shall content myself with mentioning the general heads under which treatment comes.

1. Correction of refractive errors. This is by far the most important treatment of squint, especially when proper glasses are worn early enough, cures being estimated at from 30 to 70 per cent under proper refraction.

2. Forcing or causing the child to use the squinting eye and thus develop the weak muscle. This is done in different ways, as by placing a blind or pad on the fixing eye, or by the use of atropine in the fixing eye so the child can not see near objects with that eye, thus causing it to use the squinting eye. This brings into use and thus develops the weak muscle.

3. Operative measures, as (a) muscle tucking, (b) muscle advancement, and (c) tenotomy. These operations may be single or combined, may be on one eye or both eyes, and may be done at one sitting or at several sittings.

Treatment naturally begins with correction of refractive errors, and of a necessity continues over many years, because these patients usually have to wear glasses a lifetime. Very correct refraction can be done on quite young children by retinoscopy when the accommodative apparatus is thoroughly paralyzed with atropine. Children from eighteen months to two years of age, with extremes of ametropia properly corrected, have worn glasses faithfully simply because they could see much better with the glasses than without them. No operative measures should be undertaken until correct glasses have been thoroughly tried and found not to correct the squint.

While treatment of refractive errors, and correction of muscle defects in squint, requires years of careful and painstaking work, and cures are not one hundred per cent, even in the best hands, these are not sufficient reasons why so many of these defective children should go without attention, in many instances till the child realizes its own needs and insists on its parents having something done, and in others until the child has reached its majority and seeks relief on its own accord, when the damage has been done and best results can not be attained.

Squint is a self-advertising defect that can not be hidden or camouflaged, and is a source of no little embarrassment and humiliation to the person so afflicted. And I doubt not that many of us feel a degree of sympathy, and possibly a touch of embarrassment for these unfortunate individuals, especially the adults, when we come face to face with them.

Now, how is the laity to know what should be done for these squinting eyes, and how are the parents and guardians of these children to know what should be done and when it should be done? They can know only through the advice and instruction of the medical profession —direct, definite, positive instruction. And to the ophthalmologist, when these cases do come to you for treatment, you should be ready and willing to begin and continue treatment skillfully, painstakingly and patiently.

DISCUSSION

Dr. Shaler Richardson, Jacksonville:

Gentlemen: I think we are indebted to Dr. Johnston for bringing this important subject before us. Too frequently, parents of children afflicted with squint are advised by the pediatrician or general practitioner to defer consulting an oculist until the child is more mature. Here is the great danger, for the vision of the squinting eye will surely deteriorate. Worth tells us that the faculty of vision is completely developed by the sixth year of life. Therefore, if these little patients are not properly cared for before this age, monocular vision is most certain to ensue.

I believe eighty per cent of squinting children can be relieved of this defect if treatment by careful refraction and exercise is begun early. By early, I mean as soon as the squint is detected. Many children wear glasses as early as at two years of age. Dr. Johnston has mentioned the operation of choice—that of resection of the muscle as done by Dr. Robert G. Reese of New York. This combined with tenotomy is the operation of election in my work.

The responsibility of getting these cases into the hands of the oculist rests usually with the pediatrician and the general practitioner. If they fail to advise the parents properly, the child will most likely have a deterioration of vision in the deviating eye and most certainly a monocular vision.

CONCLUSION.

Dr. Hewitt Johnston, Orlando:

The object of this paper was the hope that the profession as a whole might, when they see these children, at any place, not leave them without care, but direct them to the proper place for treatment.

TIC DOLOUREUX*

RALPH N. GREENE, M.D.,

Jacksonville.

A Viennese anatomist, Raymond Balthasar Hirsch (1765) was the first who recognized the ganglonic nature of the swelling of the sensory root of the fifth nerve, and called it, in honor of his otherwise unknown teacher, Jon Laurentius Gasser, the "Ganglion Gasseri." "Gray's Anatomy," p. 791.

The disease with which the ganglion and its branches are affected, was first described by Dr. J. Fothergill, an English doctor, in 1776. From the time of Hippocrates up to the latter part of the eighteenth century the disease had been confused with several types of involuntary laughter. Byrnes in Vol. X, "Tices Practice," gives many interesting historical facts about the disease.

The trifacial nerve known as the trigeminal or fifth nerve is the largest of the cranial nerves. It has many of the features of a spinal nerve in that it arises by two roots, has a ganglion on its posterior root and has the plural function of a spinal nerve. The trifacial nerve is important because it innervates the muscles of mastication, but is chiefly a sensory nerve. The point of origin is within the pons. The motor and sensory nuclei are situated side by side in the lateral aspect of the tegmentum of the pons, about midway between the cerebral and spinal ends of the pons. The sensory and motor bundles of this nerve are closely associated within the pons. The motor portion of the nerve receives fibres from a group of large cells situated laterally to the aqueduct of Sylvius and of the same side. The sensory fibres arise in the Gasserian ganglion and after entering the pons terminate only partially in the sensory neucleus, the larger number of them bending downward at the level of the sensory neucleus to form the descending or spiral root which may be traced so far as the second cervical segment of the spinal cord. In the cord it occupies a position back of the posterior horn. This descending spinal root of the trifacial may give trigeminal symptoms in lesions below the medulla oblongata, as in syringomelia. One may easily differentiate the small motor root from the fan-like sensory root at point of emergence from the pons. The motor root exterior to pons remains distinct until it becomes united with the third division of the trigeminal peripheral to the Gasserian ganglion. Posey and Spiller, "The Eye and Nervous System," set forth these facts.

It is vitally essential for one to have a clear anatomical understanding of the intracranial aspects of the fifth nerve in order to better comprehend the mechanics of paralysis of the facial motor branches of the nerve and involvement of the seventh nerve proper. It is possible according to Adson to traumatize the pons while avulsing the posterior root in a manner to interfere with the function of the neucleus of the seventh nerve. One must remember that there is a small branch of the fifth nerve which enters the petrous portion of the temporal bone on its anterior surface and joins the seventh nerve. In surgical approach of the ganglion it is possible to pull this branch out and the accident may give rise to hemorrhage in the facial nerve with resulting true Bell's palsy.

The extracranial main branches are three in number, the ophthalmic, superior maxillary and inferior maxillary.

Connected with the three divisions are four small ganglia; with the first the ophthalmic ganglion; with the second the sphenopalatine or Meckel's ganglion, and with the third the otic and submaxillary ganglions. The third branch only has a dual function, for extracranially it is joined by the motor branch.

It has been a time-honored method to teach that the anterior two-thirds of the tongue receive taste fibers from the trifacial. A better anatomical understanding has demonstrated that the taste fibers for the anterior two-thirds of the tongue arise from branches of the seventh or facial nerve, specifically the corda-tympani.

The sense of smell is influenced by the upper branch. The salivary and lacrymal secretions are affected by the fifth nerve. Disease of the nerve with consequent trophic disturbance may cause loss of an eye, infection of the mouth and

*Read before the Staff meeting of the Duval County Hospital, Jacksonville, December, 1926.

injury to the teeth. The fifth nerve presides over the mucus membranes of the mouth, eyes and nose. It is the great nerve of touch to the face.

Tic doloureux is a term that should be used with the idea of expressing not a painful spasm of the muscles of the face supplied by the seventh nerve. The facial spasm is a defense reaction following pain in the trigeminal nerve proper. The muscles of mastication are affected basically, of course, thus giving rise, possibly, to the "smacking" of the lips so frequently observed. Trigeminal neuralgia is a better term to use.

The pain of trigeminal neuralgia is different from any other pain affecting the body. No other nerve of the body contributes pain of similar character under any circumstances. The reason for this peculiarity of the trigeminal nerve is unknown. It affects the healthiest individuals, and seemingly without reason. Though various explanations for its origin have been suggested, none are satisfying. There is no evidence that infections of the teeth or paranasal sinuses have any bearing on its causation. There is no evident gross abnormality either of the nerve or its ganglion: nor have microscopic pathological changes been accepted as proved. Remissions in the pain may last for months, or occasionally years, but a spontaneous cure practically never occurs.

The pain is undoubtedly the most severe to which the body has fallen heir. It is essentially of the same intensity as the lancinating pain of tabes, but the pain of tic doloreux lasts longer. The characteristic pain begins suddenly, with full force, lasts from a few seconds to a few minutes (occasionally even half an hour or longer) and departs as suddenly as it came. In the interval, between paroxysms, the patient is free of pain.

One, two or three branches may be involved. The mandibular branch is at least twice as much involved as both other branches combined. The pain always begins in the same spot and repeats its form. It always remains in the domain of the trifacial nerve. One cannot over-emphasize the point that whenever a patient insists that the pains are behind the ear, down the neck, or below the jaw that the condition is not one of trifacial neuralgia.

The disease occurs equally in the two sexes and usually in middle life or after. Occasionally it may occur in the very young. Patrick of Chicago has a case in a child seven years of age. Barkley in the British Journal of Surgery, October 1921, reported a case in an eleven-year-old boy. Heredity seems to be of no importance, but more than one case has occurred in the same family.

Horsley thought that dental infection might be a cause by virtue of an ascending neuritis. This theory has to be discredited on account of the fact that there is no anesthesia or motor disturbance in the distribution of the affected branches as would be the situation in a case of true neuritis.

The manner of induction of the pain is one of its most characteristic features. Peripheral stimulation, such as brushing the teeth, touching the face, even drinking, talking, heat or cold, instantly produces an attack. At times the same individual varies in the susceptibility to these attacks. On the whole the attacks are worse in winter than summer. Lying on a pillow at night seems to provoke attacks, thus emphasizing the futility of applying heat to relieve pain and leaving unexplained why the cold of winter apparently intensifies the suffering.

It has been said that the patient's manner of indicating the location of pain is important, in that he will cautiously indicate the seat of pain by approach with his whole hand instead of one indicating finger. One must remember the psychoneurotic who has a fixed facial pain, not answering the diagnostic requirements of trigeminal neuralgia, has a functional pain, viz., topalgia.

The diagnosis of tic doloureux is rarely a matter of difficulty. There are many face pains which one is called upon to differentiate from trigeminal neuralgia. All lack the periodicity, the sudden onset or cessation and the method of induction by external stimuli. Most if not all other face pains must be regarded as functional. The reason for this rather broad assumption aside from the mental background of the patient is that it is impossible to conceive of any pain of organic origin lasting so long, and remaining unaffected even after sensation of the affected area has been destroyed. While efforts have been made to attribute this pain to an involvement of the sphenopalatine ganglion there is little to support this hypothesis.

It happens occasionally that a patient who has been operated upon for trifacial neuralgia will, in spite of the widespread anesthesia over the

areas supplied by the trifacial, insist on the presence of severe pain. This unfortunate situation occurs among patients who have been carefully studied and who have been operated by the foremost neurological surgeons of the country.' It cannot be assumed that erroneous diagnoses were made. The patients must be viewed in the light of having suffered such tremendous mental trauma that an hysterical superstructure has grown upon a true conditon of pain, leaving in the sensorium a painful expression which by careful mental training may be relieved. In the South particularly one must bear in mind that a browache may be an expression of malaria. A malarial browache may show a periodicity similar to trifacial neuralgia. One must also bear in mind that intraocular tension from glaucoma causes terrible pain, probably through mechanical stretching of the cornea, and is accompanied by anesthesia. Photophobia is a symptom not inconsistent with glaucoma and is frequently present in trigeminal neuralgia. The matter of diagnosis of these pains hinges upon a most carefully developed case history and examination, and even though the condition may appear to be definitely characteristic, one should call upon the ophthalmologist, the otolaryngologist, the roentgenologist, the internist and the clinical pathologist in eliminating those conditons which may cause confusion. It may be well to bear in mind that light touch, even a wisp of cotton, will precipitate an attack of trigeminal neuralgia. Deep pressure quickly and firmly applied is better tolerated than light touch. Deep pressure in a case of true neuritis would cause pain, light touch would not cause pain.

Sluder has described a type of neuralgia which may give rise to considerable confusion in regard to its true nature. According to Sluder's description of this "lower half headache" there is pain about the eye, upper jaw and teeth, extending to the zygoma and temple, with earache and pain in the mastoid. The neuralgic pain extends to the occiput, shoulders, neck, arm, forearm, hand and fingers. There is added the description of a sympathetic syndrone of sneezing, rhinorrhea, lacrimation and photophobia. There is said to be impairment of sense of taste and vertigo. Sluder attributes the disease to an affection of the sphenoid cells or the sphenopalatine ganglion. He cocanizes the ganglion and if relief is obtained he then injects the ganglion with alcohol.

TREATMENT.

Medicines are without effect, except as they proportionately deaden the body sensorium, such as alcohol and morphia. Eminent neurologists, for instance Dana, has insisted that massive doses of strychnia afford relief. The treatment outlined calls for two weeks in bed with progressive increase to a point of massive dosage.

The degree called for is dangerous and unwarranted. Temporary relief may be obtained by peripheral sectioning of the offending branch, but with regeneration of the nerve in a few months the pain returns in its original form. Injection of the nerve with alcohol or osmic acid has a precisely similar temporary effect. At times, however, the relief may be extended to one or occasionally even two years or more if the alcohol passes up the nerve into the Gasserian ganglion. Injection of the ganglion itself, while simple enough to perform, is extremely dangerous because the ganglion has no sheath, except the dura and the alcohol passes freely into the cerebrospinal fluid and thence attacks the unprotected brain. There are few more terrifying experiences than enduring helplessly the train of symptoms following an alcohol injection of the Gasserian ganglion.

Alcohol may be injected into separate branches. The effect will be of diagnostic importance and will enable the patient to realize the significance of the permanent anæsthesia that follows operation.

The victim of trigeminal neuralgia while willing to make almost any sacrifice, even to a point of self-destruction, to secure relief from pain, has had such terrible neuropsychiatric experiences that he may be inclined to react unfavorably to post-operative complications, particularly keratitis and anæsthesia. His attitude is at times one of amazement and wonder in placing his hand on his face and experiencing sensation as if his hand were touching a piece of wood, and with no conscious knowledge of the face being touched by one's hand. These patients in shaving themselves often express the idea that it is like shaving a piece of stone. A little preoperative education, therefore, is time and effort well spent in dealing with these patients.

Spiller of Philadelphia, America's great neurologist, first advocated in 1898 avulsion of the sensory root. Frazier later in 1901 advocated the operation. It may be mentioned that among many other notable achievements of Spiller is

the operation of cordotomy for control of pain. The operation of avulsion has been modified towards the practice of clean-cut section of the nerve in a manner to avoid traumatizing that portion of the ganglion from which the ophthalmic division arises. Post-operative keratitis seems, under this plan, to be less frequent. The temporal approach, in competent hands, may be made under local anæsthesia and is an operation practically free from mortality. The insensible cornea has to be guarded by appropriate ophthalmic protective measures. Occasionally sight has been lost, but patients who have endured trigeminal neuralgia seem to be willing to undergo this loss. Occasionally cases operated under general anæsthesia have been known to develop pneumonia with apparent peculiar susceptibility.

Dandy of Baltimore has devised a unique operation by dividing the sensory root as it emerges from the pons. With his exposure one may be assured of easy identification of the sensory root (a matter fraught with difficulty, at times with the temporal approach) and may avoid injury also to the small branch of the facial. Trauma to the ganglion at a point where the ophthalmic division arises can certainly be avoided by Dandy's method. Experimental work on dogs by Budge has showed that the pupils of the eye will contract when branches of the trigeminal nerve are divided peripheral to the ganglion; the contraction on the other hand is very slight when the nerve is divided proximal to the ganglion. Bernard found that the pupil contracted and later dilated after division of the trigeminal, but never attained the same size as the pupil on the other side. He found these phenomena to occur after both central and peripheral division of the nerve. Spiller claims that it is probable that sympathetic fibres pass to the eye after entering the trigeminal nerve through the Gasserian ganglion and as in the divided sensory root these fibers are not injured, the danger of ocular disturbance by division of this root is lessened. The trophic influence of the Gasserian ganglion on the eye may depend on the integrity of these sympathetic fibers. Doctor Dandy has observed that in a series of fifty cases operated by dividing the sensory root at its point of emergence from the pons not a single patient has developed keratitis or herpes ophthalmicus.

"Following complete extraction of the posterior root, the patient loses pain, temperature and touch perception, but this loss is not over the entire area supplied by the fifth nerve, especially over the area supplied by the third division, as there is considerable overlapping here by the cervical nerves and consequently the patient continues to feel normally over the middle of the cheek. Whereas pain, temperature and touch perception are lost, it must be emphasized that some sensation remains, namely, deep pressure sense, in the entire area supplied by the fifth nerve. This form of sensation is carried through the facial seventh which is of course not disturbed in the operation." (Radical Treatment of Trigeminal Neuralgia; Ernest Sachs, M.D., St. Louis.) One may, therefore, in the light of widest experience and most conservative advice, assume that there is only one way to cure tic douloureux, viz., by division of the sensory root of the nerve not peripheral to the ganglion but between the ganglion and the pons. There are few more satisfactory surgical results than this. Although an operation of magnitude, it is almost devoid of mortality in experienced hands. Suffering humanity owes a great debt of gratitude to an humble but great neurologist, Doctor Spiller, for having pointed out the way for relief.

I am indebted to Doctors Dandy of Baltimore, Coleman of Richmond, Dowman of Atlanta, and Sachs of St. Louis for their sincere interest in the author's investigation of the subject of tic douloureux. I have been given free access to their files and to unpublished articles.

Without clothing the group of prominent neurological surgeons mentioned in this article with any responsibility for the remarks therein set forth, it has been the effort of the author to correlate the opinions of these different gentlemen into an expression of broad agreement. In the main there is no disagreement in the minds of neurological surgeons as to the diagnosis and treatment of the terrible disease of trigeminal neuralgia.

It has been my pleasure to examine many patients who have been operated with complete success. I have had the privilege of examining a number of Doctor Dandy's cases, operated by the posterior approach and unlike a few previous cases operated by the temporal approach, these particular cases had no trophic disturbances. It is regrettable that time will not permit a more detailed discussion of the problem, but broad information rather than tiresome detail is after all usually more instructive.

INTRAPERITONEAL RUPTURE OF THE BLADDER—WITH REPORT OF CASE*

MILTON M. COPLAN, M.D.,

Miami.

We have chosen for a subject, "Intraperitoneal Rupture of the Bladder," primarily because we have such a case to report, and secondly because through this case we have been able to observe various conditions, which by both proper management and mismanagement have enabled us to draw conclusions that we hope will not only be of interest, but invoke discussion.

Contrary to the opinion of most of us, we dare assume, intraperitoneal rupture of the bladder occurs more frequently than does the extraperitoneal type. All authorities agree on this, and one goes so far as to quote a definite occurrence percentage of 61/100. Also, we wish to stress the fact that this affection is more frequent than is suspected. Since the literature on this subject has never been flooded with reports of cases, as has that of other physical lesions, many of us are of the belief that this particular accident to the urinary bladder is rare. Very often the condition is overlooked entirely when effort to determine the cause of peritoneal shock is being made. It is not infrequent that an exploratory laporotomy is done to verify a diagnosis of perforated gastric ulcer, duodenal ulcer, rupture of the liver or spleen. An abdomen filled with bloody fluid presents itself, but the site of perforation or rupture is not found. The surgeon in closing that abdomen consoles himself in the thought that said area is so situated on the "under surface" of the organ that its exposure is impossible. We have seen such a case of diagnosed rupture of the liver come to autopsy. The occurrence of rupture of the bladder is ten times more frequent in males than in females; this being due to the predisposing and exciting causes of the accident which we shall mention later. The age incident is negligible. The greatest number of collected cases, however, are of those in middle life—20 to 40 years. As a matter of interest and to explain that infants are not immune we should like to recall Besley's case in a three-year-old, and King's case in a fœtus with imperforate urethra.

Those conditions which predispose to rupture of the bladder are distension, drunkenness, pathological lesions of the vesical wall and obstructions to the flow of urine. Distension is the greatest of our predisposing elements, since it causes the bladder to rise out of the pelvis and lay exposed to direct violence. It places the organ under tension so that force might rupture it at a weakened point. Young maintains that rupture of the bladder never occurs when that organ is empty. Drunkenness not only lays one liable to accident, but also produces an insensibility to distension so that over-distension is the result. Pathological lesions such as cystitis, ulcerations, atony, etc., weaken the bladder wall at the site of the lesion. Obstruction to the outflow of urine from prostatic hypertrophy, stone in the bladder, stricture of the urethra, etc., produce atony from back pressure, and also distension from accumulated residual. External violence, falls, straining at micturition, stool or parturition, intravesical instrumentation, injections of fluids or air into the organ are the principle conditions which excite rupture of the bladder. In every instance, however, one or more of the predisposing and exciting causes must coexist before rupture of the organ is possible.

The bladder is so situated in the pelvis that almost complete protection is afforded it from violence, except when, from distension, it rises into the suprapubic region. On the other hand, it is in a dangerous position when considering the influence of pelvic fracture on the occurrence of rupture of the organ. The posterior-superior wall is the most vulnerable part of the bladder due to the manner in which the interlacing thickness of the musculature tapers off in this region, and it is in this area that most intraperitoneal ruptures occur. The basin of the bladder is adequately protected by the pelvic floor surrounding it. However, the rupture might be at the sides or in the pubic area. The mechanics of rupture from external force has never been explained to the satisfaction of all. Some claim that it is due directly to the distended organ striking against the promentory of the sacrum. Others contend that the sacrum merely acts as a buffer producing counter-pressure to the exerted force from the abdominal side with the resultant upward displacement of the bladder content.

The symptoms and physical signs produced by intraperitoneal rupture of the bladder may present a clear-cut, unmistakable picture, or again they may be such as to offer a very difficult problem. Much depends, therefore, on the

*Read before the Dade County Medical Society, November 5, 1926.

time incident—how soon or how late the patient is seen after the accident has actually taken place. We shall not attempt a grouping of the symptoms as they might appear chronologically for there is a marked over-lapping of them. For example, vomiting might be almost spontaneous, or it might ensue only after a definite peritonitis has developed; or it might be entirely absent. The most prominent, however, are the urinary signs—sudden ineffectual desire to void, which might become an almost constant desire with the patient passing only a few bloody drops in each attempt. Marked tenesmus, later associated with rectal tenesmus, pain over the suprapubic region, fluid bulging in the cul-de-sac on rectal examination, a dullness or flatness on percussion over the vesical region, absence of urine on catheterization (except in case the catheter should pass through the bladder rent into the peritoneal cavity from whence large quantities of fluid might be obtained). The abdominal picture is one of acute peritonism, distension, epigastric or hypogastric pain and tenderness; fluid dullness on percussion, etc. There are the general symptoms, as subnormal temperature, or fever after lapse of time; fast thready pulse is the general rule, but the pulse might be very slow (such a type confused us in our case). The patient has a distinct hypocratic facies and makes no attempt to walk or even sit up.

Alexander, whose investigations, surgery of, and recorded data of intraperitoneal rupture of the bladder seems to antidate all others (except Besley), who have worked on this particular urologic problem since the latter part of the nineteenth century, expounded in his first complete treatise a doctrine which we should do well to follow: "If rupture of the bladder is suspected make a suprapubic incision and inspect the prevesical space for extraperitoneal rupture. If extraperitoneal rupture is not found, then open the belly and explore." Since his day no one has improved on this means of making an immediate and accurate diagnosis. A carefully taken history is of great value in diagnosing such a case. True, we are often handicapped in obtaining accurate information by the drunken state of the patient. Or if he is in great pain he gives little response to interrogation. If rational, allow the patient to tell his own story; it is valuable. Then through specific questions, keeping in mind the various predisposing and exciting causes of rupture of the bladder, as previously mentioned, gather the facts together. By the use of all the means of clinical investigation, observation, palpation, percussion and ascultation we should ascertain our symptoms and physical signs as they present themselves at the time of examination. Aside from abdominal, pelvic and perineal deviations from the normal we must consider the temperature, pulse and blood picture. Should doubt still exist after history and physical examination is completed, then resort to such mechanical aids as may be needed. Remember, that there is always great danger of carrying infection into the bladder and peritoneal cavity. Cabot insists that no effort be made to establish a diagnosis through means of intravesical injections. Others suggest catheterization to estimate amount and type of bladder content, injection of a given amount of fluid, and determine if the return equals it. Air vesiculargrams are advocated by those who maintain that should there be an opening in the bladder wall and air is injected into the bladder, the shadows will appear also in the peritoneal cavity.

Having made a diagnosis we are ready to resort to surgery, and it is here again that we meet with a difference of opinion. Alexander, Cabot and Chetwood say operate as soon as possible, while Binnie, Da Costa and Martin state that delay until the patient has reacted from the initial shock affords more favorable prognosis. Young has collected statistics on 278 cases in great detail, and it would appear to us that the mortality rate is lower in that group which came to operation after the first thirty-six hours. The manner of surgical approach is obviously the same, that is simple laparotomy and cystotomy, although some contend that cystotomy for purposes of drainage is not essential. Having opened the peritoneal cavity, and cleaned from it the fluid and blood clots, attention is next directed to the torn peritoneum and bladder. Care should be exercised to trim any ragged edges of vesical mucosa, so that they will not by projecting into the muscular wound prevent healing. The bladder sutures should go only through the muscular wall, never including the mucus membrane. The peritoneal rent can be closed with the vesical wall or separately. The bladder is opened, and clots removed. The question of drainage next confronts us. Some advise suprapubic drainage, but never for more than three or four days. Others omit it entirely. All agree on abdominal drains if a diffuse peritonitis exists. There are

some who drain even if there is no definite evidence of peritonitis, but the majority say close without drainage. The usual laparotomy and cystotomy closures are instituted.

Unfortunately the mortality in these cases is very high. Of Young's collection of 278 cases 50% died; of Da Costa's 15 cases up to 1910, ten died. Surely in no other field of surgery is the death percentage greater, and we feel that it has been due largely to lack of interest on the part of surgical investigators to the particular affection. It has been only in recent years that thorough laboratory investigation and experimentation of vesical ruptures has occupied our studies. Just as mortality rates in other surgical fields have dropped, so will they in this when more ideal operative and post-operative essentials are known.

At this juncture, we should like to report the case of intraperitoneal rupture of the bladder that came under our care recently while on service at the Jackson Memorial Hospital. J. A. W., age 42, white male, deaf and dumb, came into the hospital at 5 p. m., Sunday, September 12th, in a highly drunken state. When seen by us at 8 p. m. he had already been attended by members of the resident staff who informed us that the patient had been admitted as a case of acute retention. Attempt had been made to catheterize him, but this was unsuccessful until a 21F sound was first passed to dilate a urethral stricture, and bleeding resulted from this procedure. A 16F catheter had then been passed and only a few drops of blood obtained. We interpreted the anuria at that time as due to blockage of this small catheter by a blood clot coming from the instrumental hemorrhage of the urethra. The patient was most uncomfortable and appeared to be greatly shocked. In his effort to show us the area of pain he would move his hand over the entire abdomen and kidney region. His temperature was 97, pulse 52 and respiration 28. WBC 18000, Hbg. 90%, and his skin was pale. There was generalized abdominal distension and muscular rigidity. There was no fluid dullness in the flanks, but over the bladder region the fluid dullness reached a point midway between the symphysis and umbilicus and this we determined as the upper level of the bladder. Rectal examination revealed nothing in the cul-de-sac, but the patient continuously motioned to the rectum as if to inform us that he had a desire to defecate. He seemed pleased when he saw the orderly make preparations to give him an enema, and appeared more at ease after its administration. The resident physicians made a diagnosis of ruptured bladder at this time, but in view of the generalized abdominal pain, nausea, slow pulse and alcoholic breath, and lack of both definite bladder signs and symptoms of internal hemorrhage, we made a working diagnosis of acute gastritis, enteritis and nephritis, until the case could be seen again in consultation with the medical staff. General therapeutic measures were instituted with the hope of bringing the patient out of his profound shock. The next morning he had reacted. Temperature was 102.4, pulse 120, respiration 34. The patient was vomiting at intervals and as yet had not voided. We then came back to the thought of rupture of the bladder and our medical consultant and Doctor Holmes, who saw the case at our request, established that diagnosis. The patient was operated at 3 p. m. September 13th. The bladder was opened, clots removed and a large right-angle tube inserted. The peritoneal cavity was opened through a continuation of the suprapubic incision. About 2000 c.c. of fluid and clots were removed. The site of rupture was found on the left inferior surface of the fundus of the bladder, and the examining finger revealed no ragged edges of mucus membrane protruding through. In view of this condition of the wound and the patient's extreme weakness, it was decided that we close without making an attempt to repair the bladder wall, but rely on our suprapubic drain to keep the bladder empty and at rest so that healing would occur. Four large cigarette drains were placed in the peritoneal cavity, and the abdomen was closed in routine manner. The patient was placed in Fowler's position when returned to bed, and hypodermoclysis and proctoclysis given to provide fluids. The case was then treated as one of generalized peritonitis with orders that nothing be given by mouth for 48 hours, and that the patient be morphinized until the respiration descended to 12 or 14 excursions per minute. Hemoplastin two c.c. every three hours, and digifoline one ampule every three hours were given to aid in arrest of hemorrhage and bolster the myocardium, respectively.

Four hours after operation a blood transfusion of 500 c.c. citrated blood was given at the bedside. For the next five days the course of convalescence was a stormy one. The tempera-

ture ranged from 100 to 104; the pulse went as high as 145. Gastric dilatation and intestinal distension were combated with gastric lavage and asafetida enemas respectively. The urinary drainage into a bottle at the bed was becoming clearer each day. On September 19th there was a decided change; the temperature dropped from 103.8 of the previous day to 98.8, pulse 120 to 80 and respiration to 24. From this date recovery was rapid and uneventful. The last of the peritoneal drains were removed on September 24th and the following day the suprapubic drain was taken out and replaced by an indwelling catheter. The catheters were changed daily and the bladder was irrigated with boric solution. On October 2nd the catheter was left out and on that same day the patient began to void through the natural channel. The patient was up in a chair on October 10th, walking on the 12th and discharged from the hospital on October 26th. Just prior to leaving the hospital the patient wrote for us the following history of his case: "On boat ride, fishing and drinking Friday, September 10th; boat hit bank, I fell out, crawled back to boat and had pain in stomach. Grew worse during day and it was bad on Saturday. Continued to drink to relieve pain. Could not pass water Saturday and Sunday, and came to hospital on Sunday afternoon with fever, cramps and very sick."

To summarize: The authorities whom we have quoted believe in a very short period of vesical drainage or none at all. We continued drainage by the suprapubic and indwelling catheter methods for twenty days without getting an infection of the bladder, and we feel to the best interest of the case. We did not close the wound in the bladder, but relied on drainage to keep this organ sufficiently at rest to allow healing by first intention. Notwithstanding absence of local signs of a true peritonitis we provided ample peritoneal drainage, and the stormy course those first few days immediately following justified our procedure. The blood transfusion, as a stimulating measure, we believe, was an important factor in the recovery of the patient. We found no literature advising transfusion for stimulation in these cases. And lastly, through our own inability to make an early diagnosis, the patient was given time to react from shock before being operated, and we are now of the opinion that the delay was a factor in saving the life of this man.

In conclusion we wish to emphasize the difficulty experienced in handling a mute, who unfortunately was also intoxicated, and believe that we have seen an unusual case in that respect. Also, we should like to express our indebtedness to the resident physicians at the hospital who gave unselfishly of their time and energy, and made possible this patient's recovery: to the medical consultant and Doctor Holmes who established the diagnosis and assisted at operation, and to those authors, Da Costa, Young, Cabot, Chetwood, Martin and others whose splendid writings on the subject have furnished us with the major portion of the information that we have embodied into this paper.

SOME PRELIMINARY REMARKS ON THE CLIMATE OF SOUTHEASTERN FLORIDA AND ITS RELATION TO DISEASE

Scott R. Edwards, M.D.,
Miami Beach.

The southeastern coast of Florida has a distinct climatic advantage in the treatment of numerous conditions to which the human body is heir, but aside from the meterological data accumulated by the government over a period of a few years, there is very little scientific data bearing on this subject. While it is generally known throughout the country that the winter months here offer a highly favorable opportunity for an outdoor existence, the almost perfect conditions which exist during at least ten months of the year for the sufferers of a majority of types of chronic illnesses, have not been sufficiently recognized or established on a truly scientific basis. Since the government station is located on the mainland the data derived from it has only a relative value for the coastal strip under consideration, which is separated from the mainland by bays and sounds of variable widths.

There is no other place in the civilized world in which the natural therapy of physical forces has been so happily combined. For a short distance north and south of the 25th parallel the Atlantic coast line of Florida has a combination of conditions modifying climate which are absolutely ideal in providing man an environment which subjects him to a minimum of the natural stresses of life, and provides a maximum of those forces which are basic in the building up of persons who are sub-standard physically.

The Gulf Stream.—The Gulf Stream is one of the most important factors. Arising in the straits of Florida, in the westward equatorial current, it flows in a direction that averages true north as far as the parallel of 31°. Along the lower Florida Coast it closely approximates the shoreline, being nearer the coast there than on any other shore after it leaves the keys. Depending upon the wind direction it is one to three miles off the shore from the keys as far north as Palm Beach. In its progress from the tropics to the higher altitudes, the transit is so rapid that time is not given for more than a partial cooling of the water. Because of this fact it is found that the Gulf Stream is very much warmer than the neighboring waters of the seas through which it flows. Due to its very close proximity to the shoreline at this point, the thermostatic influence of the water produces an almost constant temperature, and contrary to most marine climates, there is very little diurnal contrast, and correspondingly little influence over the littoral breezes.

Atmosphere.—The average day of this part of Florida has a clear atmosphere. There are several unusual factors responsible for this condition. This region occupies a position on the edge of the North Atlantic high barometric pressure area, and shares with this area its great number of clear cloudless days. The marked lack of any manufacturing industries that tend to pollute the atmosphere is a distinct advantage. On the coastal strip, except at the time of an unusually hard blow, dust is unknown. The only ground pollution of the air must come from winds strong enough to produce a sand storm, but perhaps the greatest single factor responsible for the clear air is the direction of the prevailing winds. Coming as they do from some point east of north and south, the long passage of the air through the Atlantic Ocean gives ample time for the sedimentation of any suspended material. An interesting fact in this regard is to be found in comparing the average daily actinic activity of the sun in this section. With the widespread increase of interest in the effect of ultra-violet activity of the sun on numerous chronic ills, attention has been focused on the Swiss Alps, because conditions there offer many hours of sunshine, and, the current literature would have us believe, a sun richer in ultra-violet rays and more pronounced in its effect than in any other portion of the civilized world which has been investigated up to the present time. Particular stress has been laid upon the fact that it is only in high altitudes with the corresponding rarity and clearness of the atmosphere that the actinic activity of the sun may be found in quantities sufficient to best supply this form of therapy.

With this thought in mind we have for some time past been determining the ultra-violet activity of the sun on Miami Beach, in an effort to get comparative figures with those obtained in Switzerland. While this work has not been going on over a sufficient period to justify an absolute statement, the results obtained so far have given us a higher figure than those reported from a similar method of determination by some of the investigators in Switzerland, and it is our belief that perhaps the density of the atmosphere does not have as much bearing on the problem as the lack of pollution of the atmosphere.

Soil of Shoreline.—The immediate shoreline of this southeastern part of Florida is a sandy strip which varies from four to six miles in width, and overlies a stratum of nummulitic limestone. This formation acts like a blotting paper, and insures against any surface accumulation of water. Even in September, at the time of the yearly torrential rains, the rainfall (which at times has equalled sixteen inches in forty-eight hours), is so quickly eliminated by the porous nature of the ground that in twenty-four hours the surface water is completely absorbed. The ground is absolutely free from any surface moisture. The marked lack of any great amount of vegetation, with the exception of palm and landscape foliage, is also helpful toward this end. The loose character of the soil has, in addition, a very great influence on the dissipation of accumulated heat. This dryness of soil and the scarcity of the vegetation also lessens the frequency of dew.

Humidity.—The rarity of dew, mist, and fog, speaks for a peculiar condition regarding the relative humidity. Obviously, the relative humidity must be a very tolerant figure when it is considered that fogs are an absolute rarity; that mist appears only occasionally, and then only at an early morning hour; and that dew is seldom noticeable. During 1924 the relative humidity varied only slightly throughout the twenty-four hours. An average reading at 8:00 a. m. showed 79%; at noon 67%; at 8:00 p. m. 76%.

Prevailing Wind.—Another important factor in the regulation of the climate of this section is

the prevailing wind. With an average humidity quite as high as the Atlantic Coast States farther north, even in midsummer there is less of the intensely oppressive weather so common in the States bordering the Atlantic Ocean. While in the summer months there is hot weather, sunstroke is unknown; the constant presence of a breeze is sufficient to prevent any combination of high temperature, high humidity, and stagnant air. Being on the edge of the trade winds there is a steady flow of atmosphere, mostly from the northeast, east or southeast, according to the season. The average hourly wind velocity is from 8-10 miles per hour.

Temperature.—Since the prevailing winds are from these directions, the warm waters of the Gulf Stream just to the east, assure at all seasons of the year an equable temperature, barring an occasional cold northwest wind in the winter months. However, this condition never prevails for more than one or two days. But in dealing with the sick it is an absolute necessity that some provision be made for heating their quarters at this time, since the marked contrast with the average temperature is so great.

The temperature on Miami Beach has never dropped to the freezing point. There is only slight variations between midday and midnight temperature. The prevailing winds, tempered in their passage over the Gulf Stream, show but rarely even so much as a ten-degree variation in the twenty-four hours. For a coast climate which as a rule is less equable owing to the more rapid diurnal radiations, and stronger irregular changes, the east coastal strip of Florida, with its outstanding equable climate, offers a marked contrast which is due to the prevailing winds and the Gulf Stream.

Rainfall.—Many people have an idea that there is a great amount of rainfall. While the yearly precipitation is high, reaching an average of 60-65 inches per year, when it is realized that the great bulk of this amount of rain is confined to two months of the year, it is readily seen that for the greater portion of the year the rainfall is very moderate. Specifically, in 1924 there were 65.54 inches of rain, of which 25 inches fell in October. In December of the same year there were only .52 of an inch of rainfall. There are generally one or two, possibly three, very heavy rains of twenty-four-hour duration, which make up from one-third to one-half of the total yearly precipitation.

Sunshine.—Because of the fact that this section is within the western extension of the area of high barometric pressure over the Atlantic Ocean, it insures an abundance of bright sunshine throughout the year. During 1924 there was 71% of the available sunshine existent. The occasional overcast sky is never persistent. The average amount of cloudiness does not vary greatly from month to month. It is slightly greater in the summer and fall months than during the winter. Cloudiness is least in January and February and greatest, on an average, in October.

Vital Statistics.—A glance at the health and mortality statistics for different seasons and under different conditions of weather, shows the influence of climatic factors on the state of health of the population of a given section, and the different seasons represent to a certain extent different climates. This area in Florida, with its freedom from any marked variations or sudden changes of temperature from day to day, is particularly free from the diseases that are commonly found in the temperate zone, and, one might say, almost absolutely free from the diseases generally associated with the tropical or subtropical countries.

The most important causes of death used to be the contagious diseases: Smallpox, typhoid fever, and the great pandemics. All of these are rather thoroughly under control. It is the degenerative diseases of the lungs, heart, arteries, and kidneys that are now the serious factors in human mortality.

A statistical study of these diseases shows Florida with a lower death rate than any other State in the United States registration area, and the section of Florida under discussion, although a mecca for many persons with lowered resistance, advanced age, and many other physical handicaps, shows one of the lowest death rates from these diseases found in any section of the State.

In Florida, the danger to man lay in the protozoan types of organisms, and since the bacterial pathogens were never endemic to this section, Florida is particularly free from all lower forms of pathogenic life.

It was a study of the different publications on medical climatology that prompted these remarks. It has been impossible to find any extensive or well-represented data concerning the southeastern portion of this State, and in view of the

great importance of climate in relation to health in the treatment of disease, and since perhaps this section offers a more helpful environment for a greater number of different disease processes than any other easily accessible district in the civilized world, data concerning different phases of the subject will be presented from time to time, and a study of the different subject matter properly presented.

ANOTHER CASE OF SITUS VISCERUM TRANSPOSUS*
or
TRANSPOSITION OF THE VISCERA

Jos. S. Stewart, Jr., M.D.,
Miami.

During the last year of the Civil War there appeared a report of seventy-nine cases of transposition of the viscera.[1] Of this number only six were discovered during life. In 1902[2] forty-nine cases were reported, forty of which were discovered during life—an indication of the growing diagnostic acumen of modern medicine.

The report of 1865 covered all cases found in the literature during the previous two centuries. The report of 1902 brought the total number of cases to one hundred and forty-nine. The most recent review of the literature[5] brings the total number of reported cases of transposition to four hundred.

The cause of complete or partial transposition is unknown and it appears to me that it will remain veiled in secrecy until the why and wherefore of a normal position is known.

In 1921 I reported three cases[4]: one discovered during an appendectomy when the appendix was not found in the usual position: one discovered at autopsy: one diagnosed before operation and in which the appendix was removed through a left rectus incision. I wish to add another case at this time.

White male, age 38, married, no children. Past history of no interest. Father died following an operation. Mother living and in good health. No sisters. One brother living and well, one brother died in infancy. No member of the family is transposed, nor has the patient ever heard of this condition being present in any ancestor or relative.

Examination discloses the apex beat on the right side at the fifth interspace. Liver dullness absent on the right but found on the left side. The left kidney is palpable and is several centimeters lower than the normal left kidney. The right kidney is not palpable. The spleen is not felt. The right testicle is lower than the left. X-ray examination shows a complete transposition of the abdominal and thorasic organs. Dr. Raap's letter stating that the left lung contained three lobes, the right only two. This patient is right-handed. He states that he was naturally left-handed but was forced by his parents to use the right hand.

Transposition occurs with sufficient frequency to demand our respect, especially to be remembered when we are confronted with unusual pain or symptoms in the left abdomen.

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*Read before the Dade County Medical Society, Nov. 5, 1926.

REPORT OF A CASE OF STRANGULATED AND GANGRENOUS UNDESCENDED TESTICLE*

F. A. Vogt, M.D.,
Miami.

Baby S., age 8½ months. Was first seen on April 13th, 1926.

Past history: Normal delivery, weighed eight pounds at birth, breast fed. Has had no serious illnesses of any kind.

Family history: Negative. Mother and father both well.

Present illness: On April 10th the mother noticed that the child was fretful and irritable and very restless at night. At frequent intervals during the night the baby would suddenly wake and cry out as if in pain. Mother thought it had some fever. There were no digestive disturbances, no constipation or diarrhœa. On the morning of the third day of illness, while bathing the baby, the mother noticed a lump in the left groin and immediately sought medical advice.

(*Continued on Page 194*)

*Case report read at November meeting of Dade County Medical Society.

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Putnam, Levy, Baker, Bradford, Union, Flagler, Alachua.
NINTH DISTRICT—DR. W. J. BLACKSHEAR . . . *Panama City*
Holmes, Washington, Bay.
TENTH DISTRICT—DR. HERMAN WATSON *Lakeland*
Polk.
ELEVENTH DISTRICT—DR. J. G. DUPUIS . . . *Lemon City*
Dade.
TWELFTH DISTRICT—DR. BAKER WHISNANT . . . *Fort Myers*
Glades, Charlotte, Hendry, Lee, Collier.
THIRTEENTH DISTRICT—DR. R. C. HUBBARD . . . *Tampa*
Hillsborough, Hernando, Pasco.
FOURTEENTH DISTRICT—DR. N. A. BALTZELL . . . *Marianna*
Calhoun, Jackson, Gulf.
FIFTEENTH DISTRICT—DR. JOHN E. HALL . *West Palm Beach*
Palm Beach, Broward.
SIXTEENTH DISTRICT—DR. M. M. HANNUM *Eustis*
Sumter, Lake.
SEVENTEENTH DISTRICT—DR. JOHN S. MCEWAN . *Orlando*
Osceola, Orange.
EIGHTEENTH DISTRICT—DR. S. G. HOLLINGSWORTH . *Bradenton*
Manatee, Sarasota.
NINETEENTH DISTRICT—DR. D. L. MCSWAIN . . . *Arcadia*
DeSoto, Hardee, Highlands.
TWENTIETH DISTRICT—DR. WM. R. WARREN . . . *Key West*
Monroe.
TWENTY-FIRST DISTRICT—DR. ROBT. C. BOOTHE . *Fort Pierce*
St. Lucie, Okeechobee, Indian River, Martin.

MEMBERSHIP ROSTER

In this issue of The Journal there appears, for the first time published, a complete roster by county societies of the members of the Florida Medical Association for the year 1926. The editor feels that this will be of use to all the members of the Association. Many times our office is called upon to supply such a list to those members who desire to forward communications to our membership. Be sure to file this copy of The Journal for future reference.

THE PALM BEACH MEETING

The Palm Beach County Medical Society, working with the committees from this Association, have the plans for the annual meeting of the Association well under way. The Committee on Scientific Program have formulated a very interesting and diversified program which will appear in the March issue of The Journal. The local committee on arrangements have an unusually interesting program of entertainment. If you haven't made hotel reservations for the meeting in West Palm Beach, do so without delay.

STATE NEWS ITEMS

The Pasco County Medical Society was organized on August 3, 1923, with Doctors Bradshaw, Jackson and Cannon attending—all of Pasco County. In January, 1924, Doctors Hancock and Creekmore of Hernando County became members of the society. By November, 1924, the name of the society was changed from Pasco County Medical Society to the Pasco-Hernando County Medical Society. In November, 1925, the remaining doctors who were eligible in Pasco and Hernando counties became members, giving the society a one hundred per cent membership in the two counties. About this time Doctor Dame of Citrus County joined the organization and lately the remaining doctors in this county, who were eligible, became members. At the December 14th meeting, the name of the society was again changed to the Pasco-Hernando-Citrus County Medical Society. The following officers were elected for 1927: Dr. George R. Creekmore, Brooksville, president; Dr. Geo. A. Dame, Inverness, vice-president; Dr. T. F. Jackson, Dade City, secretary-treasurer. The total membership is now fifteen. Every member is proud of the society's progress and enjoys the good feeling which exists between the members.

* * *

The following officers were elected at a recent meeting of the Alachua County Medical Society: President, Dr. S. D. Rice, Gainesville; vice-president, Dr. W. Lassiter, Gainesville; secretary-treasurer, Dr. J. L. Summerlin, Gainesville. Previous to the business meeting of the society, a dinner was enjoyed at the White House and afterwards a paper entitled "The use of Free Fascia in the Repair of Hernias" was read by Dr. Harry Peyton of Jacksonville. Accompanying Dr. Peyton was Dr. E. C. Swift of Jacksonville, who was guest of the county society.

* * *

The Associated Press on January 22nd carried the following news item concerning the postal department investigation of the "diploma mill" in Florida: "Postal Inspector R. A. Ward left today for Washington and New York in response to a telegraphic communication notifying him that four physicians arrested in those cities this week in connection with the alleged Florida diploma mill had determined to fight removal to this State. The physicians, Drs. B. Lust, prominent naturopath and publisher, W. A. Lucia, F. Trapani and F. T. Shyne, were all indicted by the December grand jury in Jacksonville. Lust is accused of having furnished a medical diploma to Dr. G. A. Munch of Tampa, who, in turn, is charged by Federal officers with having sold it. The other three are said to have practiced under licenses and diplomas illegally obtained."

* * *

Dr. W. H. McCaslan announces the removal of his offices to 603 Citizens Bank building, Tampa.

* * *

At their annual meeting, members of the Polk County Medical Society elected the following officers: President, Dr. R. H. Mooty, Winter Haven; vice-president, Dr. J. B. Lowry, Nichols; secretary-treasurer, Dr. Herman Watson, Lakeland.

* * *

The first meeting of the newly organized medical society composed of the counties of Columbia, Hamilton, Madison and Suwannee was held recently at the home of the president, Dr. E. Long, Madison. The attendance was good.

* * *

At the first annual meeting of the Hernando General Hospital, held during the past month, it was reported that 114 patients had been cared for during the first six months of the hospital's existence. The financial condition of the hospital is very satisfactory and this institution serves a great need in its community.

* * *

Dr. R. S. Lowry was recently appointed health officer for the city of Ft. Lauderdale, assuming his duties during the past month.

* * *

Dr. and Mrs. B. A. Wilkinson of Tallahassee, whose marriage was a recent event in Albany, Ga., have returned from their wedding trip and are at home to their friends on Gadsden street, having an apartment with Mrs. Chesley.

* * *

The Pasco-Hernando-Citrus County Medical Society held its annual banquet at the Tangerine Hotel in Brooksville January 13th. The president of the society, Dr. G. R. Creekmore, presided as toastmaster. A program of music and dancing was enjoyed by the guests. The following members and guests attended the banquet:

Drs. Sheldon Stringer, J. C. Page, W. J. Lancaster, J. C. Chandler, and D. G. Meighen, Tampa; Walter A. Weed and Herman Watson, Lakeland; J. T. Bradshaw, Lake Jovita; Geo. A. Dame, J. F. Miller, Inverness; T. J. Jackson, Dade City, and W. H. Cox, G. R. Creekmore, A. C. Coogler and W. S. Hancock, Jr., Brooksville.

* * *

Dr. Harry Hamilton Cooke of St. Petersburg has recently been appointed a Fellow in surgery at the Mayo Clinic, beginning April 1, 1927.

* * *

Some of the ophthalmologists and otolaryngologists are planning a get-together meeting at our next annual convention at West Palm Beach. The advisability of arranging for a luncheon or dinner during the meeting is being considered in order that all the men doing this special work may become personally acquainted with each other. If you are interested in this, send your ideas to Dr. M. A. Lischkoff at the Blount Building, Pensacola, with your suggestions.

* * *

A meeting of the Hospital Committee of the Lake County Medical Society was held Monday evening, January 17th, when it was decided to advertise the intention of the society to have presented to the next session of the State Legislature a bill authorizing the Lake County Commissioners to call for a special election to decide whether or not to issue bonds for building a county hospital. Members of the Hospital Committee are Drs. Chas. H. Lodor and M. M. Hannum of Eustis and S. C. Colley of Tavares. The committee invited Senator Edge and Representatives McKensie and Kennedy to attend the meeting to assist in planning the action to be taken.

* * *

The Hillsborough County Medical Society held their annual banquet on the evening of January 6, 1927, with the members of the Manatee County Medical Society as their guests. Dr. L. J. Efird, of Tampa, was toastmaster. The banquet was well attended by local men who had quite a number of invited guests.

* * *

The Dade County Medical Society held their January meeting at the Coral Gables Country Club. After a banquet, the program enjoyed consisted of papers and moving picture demonstrations by Dr. F. H. Albee on "Ununited Fractures of the Hip" and Dr. J. M. Burke on "The Relation Between Hernia and Trauma." Seven new members were accepted into the society.

* * *

Stanley Erwin, M.D., announces the removal of his office after January 1st, 1927, to Suite 724-6-8, Lynch Building, Jacksonville.

* * *

An advertiser from Ohio writes: "Our firm receives 'The Journal of the Florida Medical Association' and I have noted many interesting and instructive articles." The advertiser is referring to X-ray apparatus. Those who have observed the steady increase in advertising will be interested.

* * *

Dr. Arthur G. Fort, formerly of Miami, announces the opening of his offices, suite 301 Medical Arts building, Atlanta, Ga.

* * *

Dr. Leonard N. Moe announces the removal of his offices to Room 212, St. James building, Jacksonville.

* * *

Dr. C. J. Heinberg's paper, "Synergistic Analgesia," published in the January, 1927, Journal, was read before the Escambia County Medical Society at Pensacola, November 9, 1926. This notation did not appear when the article was published.

* * *

Dr. L. M. Anderson, Lake City, councilor for the Third District, has just visited officially the last county society in his district. Thursday, January 27th, Dr. Anderson, Dr. E. Long of Madison and Dr. L. J. Arnold of Lake City, together with two doctors from Thomasville, Georgia, were guests at the Taylor County Medical Society meeting. Five doctors of Taylor county were present. Owing to an unlooked for detour, the guests were delayed two and one-half hours and were very much pleased to find that the meeting, called at 12:00, was kept going until 2:30 p. m. The meeting was very interesting and the guests appreciated the many courtesies shown them by the Taylor County doctors. A total of 189 miles were traveled by Dr. Anderson, councilor for the district, and many long distance 'phone calls made in arranging the meeting.

A section meeting of the American College of Surgeons was held in Birmingham, Alabama, January 24th and 25th. Drs. Frederick J. Waas, Robert B. McIver and N. M. Heggie of Jacksonville, Leigh F. Robinson of Ft. Lauderdale and John Helms of Tampa were in attendance from Florida. The following were elected as officers of the Executive Committee: Dr. John Helms, chairman; Dr. Robert B. McIver, secretary, and Dr. N. M. Heggie, counselor. Tampa was chosen as the next place of meeting.

* * *

The annual dinner of the Duval County Medical Society will be held at the George Washington Hotel, Jacksonville, Tuesday evening, March 1st, at 8:30. The guest of honor and principal speaker of the evening will be Dr. Edward Starr Judd of Rochester, Minn., who has chosen as his subject "Surgery of Biliary Passages."

In Memoriam

W. B. McRAE, M.D.

Dr. W. B. McRae, known and loved by nearly every one in Hamilton County, died at his home in Jasper, January 7th at 10:30 p. m., following a sudden attack of heart trouble the previous evening. From the time he was stricken until his death, he was unconscious the greater part of the time. Funeral services held the following Sunday afternoon at Evergreen cemetery, Jasper, were as largely attended as any ever held there, friends from all sections of the county coming to pay the last tribute of respect to a man dearly loved by all. Dr. McRae was sixty-two years of age and had practiced medicine at Jennings and around that section for thirty-one years, moving to Jasper only a few years ago. As a practitioner, he held the highest esteem of the medical profession, and as a man was loved and respected by all who knew him. He was of that old school of medicine who never heard a call that he did not answer. The human side was always before him and it is told of him that the business side of the profession was a secondary matter. Though he did not gain in a material way, it is declared by his friends that he laid up great riches in the affections of the people to whom he ministered over a long period of time.

* * *

B. L. PADGETT, M.D.

Dr. B. L. Padgett, well-known citizen and practicing physician in Hastings for the past nineteen years, died suddenly January 5th. He had not been in the best of health for some time, but did not complain of feeling ill until a few days previously. Dr. Padgett graduated from Charleston, S. C., Medical School twenty years ago and came immediately to Hastings. He served as medical officer during the World War, stationed at Camp Greenleaf, Chattanooga, Tenn. He was Hastings' first mayor, receiving his appointment from Governor Gilchrist when the town received its incorporation charter in 1913. He also served on the town council. Dr. Padgett was unmarried and is survived by his mother and several brothers and sisters.

* * *

JOSIAH MILLARD CODY, M.D.

Josiah Millard Cody was born in Ontario, Canada, October 18, 1861. He graduated from Rush Medical College, Chicago, in 1886. He began to practice the following year in Tremont, Illinois, where he continued uninterrupted for thirty-three years. He was married to Miss Belle Davis, daughter of A. J. and Martha Gowdy Davis, June 4, 1890. Dr. Cody moved to Vero Beach in 1919 with the intention of retiring from practice. The demands for his services became so great, however, that he opened an office in 1923. He died in the Victoria Hospital, Miami, January 8, 1927, of a pulmonary abscess and pneumonia. He leaves to mourn his loss a wife and a daughter, two brothers and one sister.

* * *

CHARLES M. ROBERTS, M.D.

Dr. Charles M. Roberts of Umatilla, Lake County, Florida, died at 10:30 p. m. Thursday, December 30, 1926, as the result of the wrecking of an automobile which he was driving. The automobile turned turtle on the highway between DeLand and the St. Johns river while Dr. Roberts was driving toward his home in Umatilla. Dr. Roberts was 45 years of age. He graduated from the University of Tennessee in 1910 and for nineteen years has practiced in Umatilla. He was at one time president of the Lake County Medical Society.

NORTH AMERICAN PHYSICIANS ARE INVITED TO VISIT THE CLINICS OF EUROPE AGAIN IN 1927

In May this year a group of physicians with members of their families from the United States and Canada, under the direction of the Interstate Post-Graduate Medical Association of North America, will sail from New York to visit the following leading medical centers of the Old World:

London, Edinburgh, Oslo, Stockholm, Upsala, Lund, Copenhagen, Hamburg, Leipzig, Munich, Strasbourg, Heidelberg, Frankfort and Paris.

This will be the third year that foreign assemblies have been conducted under the auspices of this organization. Those of 1925 and 1926 were exceedingly successful and of great benefit to the physicians who took advantage of them. No doubt the 1927 assemblies will meet with equal success.

In including Norway, Sweden and Denmark in the itinerary, the Association is offering the profession an exceptional opportunity to visit and study in some of the finest clinics in the world.

The group of physicians will be limited to a number that can be comfortably accommodated in the clinics which will cover the entire field of medical science.

The price of the trip will be kept as low as possible and yet furnish first-class accommodations. It will be between $1,000 and $1,100. All physicians who are in good standing in their State or Provincial Society may register. Further information may be obtained from the Managing Director, Dr. William B. Peck, Freeport, Illinois, or the Travel Department of the American Express Company, 65 Broadway, New York, N. Y., who have charge of the transportation.

WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION

OFFICERS:

President—Mrs. Wilburn Lassiter, Gainesville.

First Vice-President—Mrs. A. H. Freeman, Ocala.

Secretary and Treasurer—Mrs. M. M. Hannum, Eustis.

Corresponding Secretary—Mrs. G. C. Tillman, Gainesville.

THE WOMAN'S AUXILIARY.

The formation of the Woman's Auxiliary to the Florida Medical Association brings together a group of women whose purpose will be to assist the work of the medical profession through wives of the physicians, reach the needs of communities and assist in the advancement of health conditions, working with the women's organizations throughout the State, which look for the advancement of health conditions.

Through this organization we hope to provide a better acquaintance among doctors' families—to organize an auxiliary in each county and assist in any way we may be called upon in the entertainment of state or district meetings of the men who compose this noble profession. We ask for the cooperation of each physician in completing our organization plans at the annual meeting to be held in West Palm Beach April 5-6. Bring your wife with you that she may enjoy the many benefits gained from this our first anniversary.

Plans for the two days' program will be given in the next issue of The Journal. Mrs. George M. Dawson of West Palm Beach has been appointed chairman of entertainment for ladies, while plans for the business session were arranged by the executive committee at a meeting held in Ocala January 31st.

ANNA B. LASSITER, President,
Woman's Auxiliary, Florida.

ADVERTISERS' NOTES

ABBOTT LABORATORIES SALES SCHOOL

The salesmen of the Abbott Laboratories and the Dermatological Research Laboratories from the Middle West and the South met in the home offices of that company in North Chicago, the week of December 21. Over forty representatives were present at this meeting, including one from the Pacific Coast, two from Texas, three from Canada, one from Atlanta, Ga., and three from the Eastern sales force.

Four days were spent in intensive study of the Abbott and D. R. L. products. Playlets were staged illustrating sales points and round tables were conducted on subjects of importance to the salesmen and the firm. On Tuesday evening, December 28th, the salesmen were invited to attend the annual Christmas dinner and dance given by the employees of the Abbott Laboratories. Over 500 were in attendance at this

function. On the following evening the salesmen were entertained at a banquet given by the Abbott Laboratories in their own cafeteria, recently installed at the North Chicago plant. Addresses were given at this meeting by Dr. Alfred S. Burdick, president of the Abbott Laboratories, who reviewed the progress of the company and introduced Dr. G. W. Raiziss, professor of chemotherapy, University of Pennsylvania, who spoke on the newer arsenical compounds, particularly Bismarsen, a new combination of bismuth and arsenic; Dr. Roger Adams, professor of chemistry, University of Illinois, who told of his investigations in the field of chaulmoogric acids; and Dr. A. G. Young of the University of Michigan, who spoke of the treatment of arthritis deformans with o-iodoxy benzoic acid, amidoxyl.

THE CONTROL OF DIPHTHERIA

Notwithstanding the fact that the prevention of diphtheria is engaging the attention of city boards of health and private practitioners throughout the country, and many thousand immunizing treatments have already been given, it will be a long time, we fear, before diphtheria antitoxin goes out of use, or even before the need for it becomes appreciably less than it is now.

The makers of diphtheria antitoxin, therefore, are to be commended for doing their utmost to improve the quality of the antitoxin and the syringe package in which it is put up. Parke, Davis & Co., who began supplying diphtheria antitoxin more than thirty years ago, announce some recent developments in the purification of this product and the concentration of the dose volume. See their advertisement in this issue, "Latest Refinements in Diphtheria Antitoxin."

REPORT OF A CASE OF STRANGULATED AND GANGRENOUS UNDESCENDED TESTICLE

(*Continued from Page 188*)

Physical examination: Baby is well developed and nourished. Head, neck, thorax and extremities negative. Abdomen slightly distended, no muscular rigidity. In the region of the upper part of the left inguinal canal, a firm, tender, nonreducible and nonfluctuant mass was palpated. There were no evidences of abrasions or sores on the genitalia or extremities. No impulse was felt over the mass when baby cried. Both testicles were absent from the scrotum.

Temperature 101 per rectum, pulse 120, respiration 30.

Preoperative diagnosis:

1. Strangulated undescended testicle.
2. Enlarged inguinal lymph gland.
3. Hernia.

Operation advised.

Operation: Under light ether anæsthesia an incision was made through the skin over the left inguinal canal. The aponeurosis of the external oblique was incised from below upwards, thus opening into the canal. The spermatic funiculus was absent, and in the extreme upper angle of the canal was found a mass about the size of a large olive. This was freed from adhesions and proved to be a gangrenous testicle. The testicle was further exposed by traction and the funiculus was found to be twisted on itself several times, cutting off the blood supply from the organ. The funiculus was untwisted, hot towels applied to the tissues, but after several minutes circulation did not return. The testicle was then removed and the incision closed in the usual manner without drainage.

Pathological report by Dr. Youmans is as follows:

Testicle: Gross appearance small, enclosed in sac; very dark in color, suffused with blood.

Microscopic section shows a fairly well preserved fibrous capsule and in places the stroma is in a fair state of preservation. In other places the stroma has lost structual characteristics. No where is the glandular tissue preserved except in outline. The blood vessels throughout are markedly dilated and there is diffusion of blood throughout the tissue.

The baby made an uneventful recovery.

Strangulation of an undescended testicle may occur at any age, but is most common during the ten-year period immediately following puberty. Untreated it leads to asceptic gangrene, abscess or more commonly simple atrophy. Seventy-five per cent of the cases have to be castrated. If operated on early enough there is a possibility that the testicle might be saved.

An interesting observation in this case was that the right testicle had not descended and could not be felt in the canal.

MEMBERSHIP ROSTER
FLORIDA MEDICAL ASSOCIATION
CALENDAR YEAR 1926

ALACHUA COUNTY MEDICAL SOCIETY.

Dell, J. M., Gainesville.....President
Thomas, W. C., Gainesville.....V.-Pres.
Lassiter, W., Gainesville...Sec'y-Treas.
Biggs, E. L.....Starke
Bishop, B. M.....Archer
Brantley, Z. Grandin
Colson, J. H. Gainesville
Dailey, I. A.....Micanopy
DePass, M. H. Gainesville
Elmore, W. T., Baird Bldg., Gainesville
Floyd, G. M.....Hawthorne
Goode, J. A.....Alachua
Gray, C. R.....Trenton
Hodges, J. H.....Gainesville
Milton, D. G.....Cedar Keys
Parks, W. B.....Starke
Preston, H. F.....Melrose
Pridgeon, C. L.....Waldo
Rice, S. D.....Gainesville
Sherouse, G. W.....Campville
Smith, D. T.....Gainesville
Summerlin, J. L.....Gainesville
Tillman, G. C.....Gainesville
Turner, J. W.....Sumner
Turner, S. L.....Williston
Twiggs, J. H.....Archer
Watkins, J. D.....Micanopy
Weeks, L. R.....Trenton
Willis, J. M.....Williston
Young, Wm. C.....Chiefland

BAY COUNTY MEDICAL SOCIETY.

Whitefield, J. M., Panama City, President
Lowe, W. G., Lynn Haven.....V.-Pres.
Nixon, J. M., Panama City, Sec.-Treas.
Adams, D. M.....Panama City
Blackshear, R. D.....Panama City
Blackshear, W. J.....Panama City
Lee, W. J.....Panama City

BRADFORD COUNTY MEDICAL SOCIETY.

King, R. Seeber, Lake Butler, Acting Secretary
Maines, John E.....Lake Butler
Mann, John M.....Lake Butler
Middleton, W. E.....Starke

BREVARD COUNTY MEDICAL SOCIETY.

Page, W. C., Cocoa.....President
Bean, I. F., Melbourne...Vice-President
Ferguson, R. D., Titusville...Sec.-Treas.
Hicks, I. K.....Melbourne
Hughlett, W. S.....Cocoa
Thomas, A. F.....Titusville
White, C. B.....Cocoa

BROWARD COUNTY MEDICAL SOCIETY.

Maxwell, Leslie H., Ft. Lauderdale, President
Walker, H. A., Hollywood Beach Hotel, Hollywood..Vice-President
Robinson, Leigh F., Ft. Lauderdale, Secretary and Treasurer
Carter, D. E.....Ft. Lauderdale
Hippensteel, R.....Ft. Lauderdale
Johnston, J. A.....Ft. Lauderdale
Klussman, H. A.....Ft. Lauderdale
Klussman, R. M., First National Bank Building Ft. Lauderdale
Lingeman, R. B.....Ft. Lauderdale
Lowry, R. S.....Ft. Lauderdale
McClellan, G. S.....Pompano
McLowry, Elbert Hollywood
Peavy, H. J., First National Bank Building Ft. Lauderdale
Repass, R. E.....Ft. Lauderdale
Skiff, F. S.....Ft. Lauderdale
Smallwood, Robert Ft. Lauderdale
Stanford, J. A.....Ft. Lauderdale
Stoval, R. H., First National Bank Building Ft. Lauderdale
Stranahan, J. O. Ft. Lauderdale
Wigg, C. J.....Ft. Lauderdale
Winsor, S. A.....Pompano

COLUMBIA COUNTY MEDICAL SOCIETY.

Dyer, James H., Lake City....President
Arnold, L. J., Lake City.....Secretary
Anderson, L. M.....Lake City
Anderson, T. S.....Live Oak
Bates, T. H. Lake City
Blalock, A. L.....Madison
Caldwell, Herbert Lake City
Farnell, P. C.....Lake City
Gable, J. D.....Lake City
Harkness, R. B.....Lake City
Long, E. Madison
Tyre, C. M.....High Springs
Whitlock, W. E.....High Springs
Witt, T. W.....Lake City

DADE COUNTY MEDICAL SOCIETY.

Lyell, R. O., 305-10 Huntington Building, Miami President
Woodward, R. C., Professional Building, Miami Vice-President
Raap, Gerard, Professional Building, Miami Sec. and Treas.
Adkins, E. H., 210 Collins Avenue Miami Beach
Agos, I. H., Box 2626.....Miami
Allen, O. F., 152 S. E. Fourteenth Street Miami
Aranovitz, S., Professional Building Miami
Babcock, Donald T., Calumet Building Miami
Babcock, H. C., Calumet Building Miami
Baker, Juel M., 719 Seybold Building Miami
Baker, L. A., 570 West Flagler Street Miami
Barfield, J. O., 312 N. W. Third Avenue Miami
Barge, H. A., 405 Calumet Building Miami
Barge, W. J., 405 Calumet Building Miami
Benton, G. H., 156 East Flagler Street Miami
Bergmann, J. E., 835 Lincoln Road Miami Beach
Brannen, Cecil, Box 85....Coral Gables
Burch, R. N., 2846 N. Miami Avenue Miami
Burley, B. T., Calumet Building.....Miami
Campbell, E. E., 227 N. E. 5th Street Miami
Caplan, L., 1207 W. Flagler Street Miami
Chambers, S. E., City Health Department Miami
Chandler, G. E., Calumet Building Miami
Cleghorn, Chas. D., Ralston Building Miami
Coleman, W. S., 611 Professional Building Miami
Conger, G. D., 2164 N. W. 28th Street Miami
Coplan, M. M., 601 Professional Building Miami
Couric, C. S. Lemon City
Crager, J. C., Professional Building Miami
DeBoe, M. P., First National Bank Building Miami
DePuis, J. G....Lemon City and Miami
Dunnaway, C. E., Box 723.....Miami
Edwards, S. R., Allison Hospital Miami Beach
Elgin, L. W., 710 Miami Bank & Trust Building Miami
Field, S. E., Box 625 Lemon City
Flipse, M. J., 306 Huntington Building Miami
Fort, A. G. Miami
Fossey, Herbert L., 21 N. E. 36th Street Miami
Fox, H. H., Congress Building...Miami
Foxworthy, F. W., 310 First National Bank Building Miami
Franklin, C. G., Box 75..Coconut Grove
Freeman, Mary Perrine
French, E. D., Hippodrome Building Miami
Garceau, G. J., Allison Hospital.....Miami Beach
Ghertler, Max, 270 N. E. 23rd Street Miami
Gowdy, F. A., 212 Republic Building Miami
Gowdy, R. A., Olympia Building, Miami
Gramling, W. S., 305 N. E. 17th Street Miami
Graves, J. R., Hippodrome Building Miami
Grimes, D. H., Box B.....Lemon City
Haggard, W. A., 203 Townley Building Miami
Haisfield, H. B., 3002 Grand Avenue Coconut Grove
Hall, E. J., Professional Building Miami
Hall, T. B., Aladdin Bldg., Miami Beach
Hall, M. W., Professional Bldg., Miami
Harris, D. W., Professional Bldg., Miami
Harris, R. M., 402 Calumet Bldg., Miami
Hatch, E. B., 71 N. E. Eleventh Street Miami
Hodsdon, B. F., Box 923 Miami
Hodsdon, L. A., 601 N. E. First Avenue Miami
Holmes, R. J., Professional Bldg., Miami
Hopkins, Heywood H., 223 McDuff Avenue Jacksonville
Hotchkiss, W. T., Alladin Bldg., Miami
Hutchinson, L. R., 7912 N. E. Third Avenue Little River
Hutson, T. W., 5 N. E. Second Avenue Miami
Jaudon, E. K., 404 N. E. 27th Street Miami
Jeffery, S. L. Coconut Grove
Johnson, Estella, Box 352, Coral Gables
Jones, W. C., Calumet Building, Miami
Jordan, W. B.....Homestead
Jordan, W. M., 835 Lincoln Road Miami Beach
Keeler, F. L., Box 1250.....Miami
Keely, J., Chester Apartments...Miami
Kelley, E. E., 283 Halcyon Arcade, Miami
Kemp, A. J., Congress Building, Miami
Kennon, C. L., Calumet Building, Miami
Kirsch, M. D., Huntington Bldg., Miami
Lanier, W. T., 19 S. W. Seventh Avenue Miami
Leavitt, H. A., 127 N. E. Fifth Street Miami
Light, S. D. W., Calumet Bldg.. Miami
Lithgow, Wm. D., 245 N. E. 25th Street Miami
Litterer, A. B., U. S. Bond & Mfg. Co. Building Miami
Lott, Y. C., 202 Bedford Bldg....Miami
Lucinian, H., Huntington Bldg., Miami
Lustgarten, A., Tuttle Hotel.....Miami
McGunagle, J. E., Box 217.....Miami
McKenzie, J. S. Little River
McKibben, W. M., 205 Calumet Building Miami
McLean, E. H., 512 Huntington Building Miami
Martin, Benj. J., 37 N. E. 1st Avenue Miami
Martin, M. C. Little River
Manson, P. J. Little River
Milton, J. D., 127 N. E. Fifth Street Miami
Nabers, L. W., 3618 N. E. Second Avenue Miami
Newport, P. E., 566 S. W. Third Street Miami
Nichol, E. S., 306 Huntington Building Miami
O'Quinn, L. H. Hialeah
Ownbey, A. D., 1237 S. W. Eighth Street Miami
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Paulk, George A., Congress Building Miami
Payne, J. W., Professional Building Miami
Pearson, Homer, 1207 W. Flagler Street Miami
Pearson, R. J., 544 W. Flagler Street Miami
Peters, E., 105 S. E. First Street Miami
Pierson, Nelson, First National Bank Building Miami
Preston, R. W., 12 S. W. 17th Court Miami
Quillian, W., Laidlaw-Southworth Building Coral Gables
Roche, C. F. Miami Beach
Rowlson, I. A., Box 424....Little River
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Shaw, E. Clay, 1133 Fifth Street Miami Beach
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Simpson, J. R., 1051 Seybold Building Miami
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Skaggs, P. T., 145 E. Flagler Street Miami
Smith, M., 405 Huntington Building Miami
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Stimson, Horace, 609 Miami Bank & Trust Building Miami
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Thomas, M. D., Box 237..... Miami
Thorne, J. I., Seybold Building... Miami
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Tower, J. B..... Homestead
Tumlin, C. E., 203 Townley Building Miami
Turner, J. C., 212 E. Flagler Street Miami
Vinson, W. J., 403 Professional Building Miami
Vogt, F. A., 207 Calumet Building Miami
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Ward, Frank, W. Flagler Street and 17th Avenue Miami
Watters, W. H..... Coconut Grove
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Bowen, F. J., St. James Building Jacksonville
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Fisher, L. C..... Green Cove Springs
Fort, F. L., Professional Building Jacksonville
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Harris, W. G., St. James Building Jacksonville
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Holden, G. R., 510 Laura Street Jacksonville
Holloway, L. W., St. James Building Jacksonville
Horne, H. F., St. James Building Jacksonville
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Ives, H. A., 15 Forest St., Jacksonville
Jackson, C. M., Adair Building Jacksonville
Jelks, Edward, Riverside Hospital Jacksonville
Jennings, C. L., Professional Building Jacksonville
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Johnston, C. W., St. James Building Jacksonville
Jones, F. C., Graham Building Jacksonville
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Killinger, R. R., St. James Building Jacksonville
Kirby-Smith, J. L., Professional Building Jacksonville
Kirk, W. W., Professional Building Jacksonville
Knauer, W. J., Buckman Building Jacksonville
Knight, A. C., Professional Building Jacksonville
Love, J. D., 1463 Oak St., Jacksonville
Mabry, C. B., St. James Building Jacksonville
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Manhoff, Ben, 712 Laura Street Jacksonville
Manning, W. S., St. James Building Jacksonville
Martin, P. H., Professional Building Jacksonville
May, R. D., Professional Building Jacksonville
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Moe, L. N., 313 Professional Building Jacksonville
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Morris, S. A., 237 W. Duval Street Jacksonville
Norris, S. R., St. James Building Jacksonville
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Peterson, C. A., St. James Building Jacksonville
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Upchurch, N. A., City Board of Health Jacksonville
Van Schaick, H. D., St. James Building Jacksonville
Veal, E. W. South Jacksonville
Waas, F. J., Professional Building Jacksonville
Washburn, Clayton, St. James Building Jacksonville

*Deceased.

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Wilkinson, H. A., Professional Building Jacksonville
Wilson, A. K., St. James Building Jacksonville
Wilson, J. F., St. James Building Jacksonville
Woolsey, B. F., St. James Building Jacksonville

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Arroyo, C. F., Citizens Bank Building Tampa
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Barker, F. T., Brans Building...Tampa
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Beyer, A. K., Citizens Bank Building Tampa
Bidwell, A. M., 411 First National Bank Building Tampa
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Bottari, G. C., 7th Avenue and 19th Street Tampa
Cameron, F. A., Gas Building...Tampa
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Carter, E. F., 1719 Grand Central Avenue Tampa
Chandler, J. C., Citrus Exchange Building Tampa
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Cook, H. M., Tribune Building..Tampa
Costa, F. J., 1425½ Seventh Avenue Tampa
Cowart, J. T., 9065 Romi.....Tampa
Crum, J. W., 2023½ Seventh Avenue Tampa
Daniels, B. A., Tribune Building Tampa
Dickinson, J. C., Citizens Bank Building Tampa
Draper, A. D., 5607 Florida Avenue Tampa
Duke, R. R., Citizens Bank Building Tampa
Dyer, W. H., 2116 Seventh Avenue Tampa
Edwards, W. E. Safety Harbor
Efird, L. J., Stovall Building....Tampa
Ely, R. A., Bruen Webb Building Tampa
Estes, J. L., Stovall Building....Tampa
Farrior, J. B., Citizens Bank Building Tampa
Favor, H. M., 402 Citrus Exchange Building Tampa
Fluker, C. B., Tribune Building Tampa
Forbes, S. B., Citizens Bank Building Tampa
Foster, J. C., 2023½ Broadway, Tampa
Gilbert, Elsie, 6508 Central Avenue Tampa
Gilmer, E. S., Citizens Bank Building Tampa
Glass, R. E., 914 14th Avenue..Tampa
Grantham, J. M., 513½ Franklin Street Tampa
Gyland, Stephen, Stovall Building Tampa
Hampton, H., Citizens Bank Building Tampa
Hardy, G. E. W., Stovall Building Tampa
Helms, J. S., Citizens Bank Building Tampa
Higgins, A., Gas Building.....Tampa
Holloway, E. W., 2051½ Seventh Avenue Tampa
Holton, W. J. Plant City
Hubbard, R. C., 2220 Seventh Avenue Tampa
Ives, A. C., Stovall Building....Tampa
Jefferson, R., Giddens Building..Tampa
Jenson, H. J., Nebraska and Elizabeth Streets Tampa
Jobson, A. M. C., Citizens Bank Building Tampa
Jones, A. B., Bayside Hospital Tampa
Knauf, A. R., Citizens Bank Building Tampa
Knight, J. C. Plant City
Lake, E. T. Sulphur Springs
Lancaster, W. J., Citizens Bank Building Tampa
McEachern, J. R., Citrus Exchange Building Tampa
McRay, E. H., Citrus Exchange Building Tampa
Maguire, T. C. Plant City
Martin, D. D., 906 South Rome Building Tampa
Meighen, Douglass, Gas Building, Tampa
Mills, David, 2107 N. Jefferson, Tampa
Mills, J. H., 907 17th Avenue....Tampa
Mitchell, L. B., Giddens Building, Tampa
Moore, T. J., Tribune Building..Tampa
Murphy, H. K. Mulberry
Nelson, R. G., 325 Lafayette Arcade Tampa
Ortega, Ralph, 1805 Fifteenth Street Tampa
Oppenheimer, L. S., Citizens Bank Building Tampa
Pate, J. C., 1107 First National Bank Building Tampa
Rankin, G. C., 715 Florida Avenue Tampa
Rowlett, W. M., Citizens Bank Building Tampa
Sanchez, B. A. Plant City
*Sandlin, Joseph T., Stovall Building Tampa
Saxton, J. J., Citrus Exchange Building Tampa
Smith, Burdette, Citrus Exchange Building Tampa
Smith, H. Mason, 903 Tampa Theatre Building Tampa
Smoak, Edw., Citizens Bank Building Tampa
Snow, H. O. Pierce
Spengler, N. L., 903 Tampa Theatre Building Tampa
Stringer, Sheldon, Gidden Building Tampa
Taylor, J. W., Citizens Bank Building Tampa
Thorpe, Franklyn, 201 Lafayette Arcade Tampa
Torbet, R. F., Stovall Building..Tampa
Truelson, Thomas, Citizens Bank Building Tampa
Vaughn, Cecil, Stovall Building, Tampa
Vinson, J. C., Box 571.....Tampa
Weekly, A. S., Lafayette Arcade Building Tampa
Williams, Horace, 212 W. Lafayette Tampa
Wilson, S. S., 5309 Central Avenue Tampa
Winton, M. R., Citrus Exchange Building Tampa
Young, C. T. Plant City

*Deceased.

INDIVIDUALS.

Anderson, J. M. Alton
Oglesby, C. R., Box 154..Tampa Shores
Paul, L. H. Bonifay
Strong, S. B., care Hospital, Marcane, Oriente, Cuba

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Peek, E. G. Ocala
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Porter, Joseph Y., Sr. Key West
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Chiles, J. H. Orlando
Christ, C. D. Orlando
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Collins, C. J. Orlando
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Dodds, Wm. St. Cloud
Edwards, G. H. Orlando
English, D. E. Orlando
Folsom, S. A., Box 1137 Orlando
Ford, J. A. Orlando
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Gwynn, H. W. Orlando
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Johnston, H. Orlando
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Lawson, B. H. Winter Garden
Lewis, P. M. Orlando
McElroy, S. Orlando
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Osenbach, W. Orlando
Osincup, G. S., The Amherst Orlando
Perkins, H. Holopaw
Persons, W. C., Church Street, Orlando
Redding, J. L. Orlando
Robson, J. N. Sanford
Scott, Sam Ocoee
Sinclair, K. Y. Orlando
Sinclair, W. E., Clinic Building, Orlando
Spiers, W. H., Box 1137 Orlando
Toles, L. W. Orlando

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Brown, V. L., Citizens Bank Building West Palm Beach
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Carlisle, J. L., 6 McGinley Building West Palm Beach
Cason, J. R. Delray
Clay, B. S., 6 McGinley Building West Palm Beach
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Denison, R. C. Lake Worth
Fields, S. E. Delray
Gardner, W. H., Guaranty Building West Palm Beach
George, W. W., Citizens National Bank Building West Palm Beach
Gerlach, Earl B., 708 Kanuga Drive West Palm Beach
Gerlach, H. P., 326 Lakeview Avenue West Palm Beach
Gill, R. S., Citizens Bank Building West Palm Beach
Gunter, T. D., Guaranty Building West Palm Beach
Hall, John E., 119 South Narcissus Street West Palm Beach
Heath, G. W., Commercial Bank Building West Palm Beach
Henry, G. F., Citizens Bank Building West Palm Beach
Herman, F. P., McGinley Building West Palm Beach
Herpel, F. K. West Palm Beach
Jared, Vernon M., Health Department West Palm Beach
Lewis, R. G. West Palm Beach
Merrill, C. M., 425 Australian Avenue West Palm Beach
Netto, Lloyd J., 409 Como Building West Palm Beach
Odeneal, T. H. West Palm Beach
Papot, Grace E., 509 Guaranty Building West Palm Beach
Pearson, Colquitt Kelsey City
Peek, L. A. West Palm Beach
Pittman, J. H. West Palm Beach
Powell, J. A. West Palm Beach
Rodrick, A. F., Box 1087 Palm Beach
Rowe, A. L. Lake Worth
Rozier, L. M., Farmers Bank West Palm Beach
Sayad, William Y. West Palm Beach
Schliffli, O. F. West Palm Beach
Shakelford, C. W. West Palm Beach
Shackelford, W. L. West Palm Beach
Smart, B. F. Lake Worth
Sory, B. B., Jr. Lake Worth
Stone, V. D., Guaranty Building West Palm Beach
Tatom, F. L. Lake Worth
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CONTENTS

PAGE

Bronchial Asthma and Its Relation to Sinus Disease in Children 200
M. A. Lischkoff, M.D., F.A.C.S., and James H. Fellows, M.D., Pensacola.

Early Pulmonary Tuberculosis Rœntgenologically Considered 204
H. O. Brown, M.D., Clearwater.

A Case of Tetanus 207
William H. Watters, A.M., M.D., Miami.

PAGE

Extragenital Chancre 208
C. F. Roche, M.D., and Thomas B. Hall, M.D., Miami Beach.

The Palm Beaches Await the Annual Meeting of the Florida Medical Association 209
Jane Floyd Buck, West Palm Beach.

Program of the Fifty-Fourth Annual Meeting of the Florida Medical Association 214

Editorials: (1) The West Palm Beach Meeting; (2) The Medical Conference 216, 217

Report of Councillors, Florida Medical Assn..... 217

State News Items 221

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T. A. Soule

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BRONCHIAL ASTHMA AND ITS RELATION TO SINUS DISEASE IN CHILDREN*

M. A. Lischkoff, M.D., F.A.C.S.,
and
James H. Fellows, M.D.,

Pensacola.

Dr. M. A. Lischkoff:

The older classification of bronchial asthma included one type definitely set aside as reflex nasal asthma. These cases were not referred to the rhinologists for cooperative treatment, but drifted into their hands because of disturbances in the nose that called for relief. Occasionally there were reports of patients with asthmatic history, who consulted the rhinologist for intercurrent infection, after which infection was cured, the asthmatic symptoms did not recur. It is not with the idea of placing a new set of facts before you that I discuss this, but to stress the importance of closely observing them and increase our knowledge of this subject.

Anatomical studies of the nose and accessory sinuses, during the past few years, have brought a much clearer conception of the relation of sinus disease to systemic infection, and now the pediatrist or surgeon is almost as well informed about the antrum of Highmore or the ethmoidal cells as the sinuologist. These sinus cavities are lined with mucous membrane, which is exposed to the same pathological processes and inflammatory conditions as the other mucous membrane in the nose and throat, of which it is continuous.

Recurrent nasal sinus disease, whether due to anatomical obstructions or deformities that impair the normal ventilation, or recurrent coryzas, pass through the same pathological changes in undergoing chronicity. When the natural ostea are occluded, the retained infected material is incubated in this cavity, and if drainage is not established the infection soon becomes systemic. If these cases are seen after the acute symptoms referred to the sinus have disappeared, they then become foci of infection, which are sometimes difficult to demonstrate. Recent experimental studies have shown that India ink or bacterial emulsion injected into the nostrils of animals produce evidence in the upper respiratory tract all the way to the terminal bronchi and alveoli. There were no lesions of the digestive tract and only slight evidences were seen in the kidneys and spleen. A few of the conclusions reached were that lymphatic absorption from the antrum is by way of the submaxillary and internal jugular nodes, to the lymph ducts, right side of the heart, and lungs. Occasionally the retro-sternal nodes were reached by absorption from the antrum. Where the mucosa was uninjured, there was little or no absorption. Most of us have been able to corroborate this by clinical evidence. The literature is filled with case reports observed by removing the sources of infection in the nose, and it is with this brief introduction that I wish to discuss the cases just reported.

In the case, P. C., a small boy who had no antrum infection at the time of his tonsillectomy, had his first attack shortly after the development of pertussis. There was no evidences of sinus infection at that time, and it was only after a long time that there was enough evidence in the sinuses to corroborate our suspicions and make a diagnosis. He yielded promptly to local treatment, ventilation and drainage.

In the case, M. H., a little girl, four years old, we were never able to demonstrate any pus in her sinuses. In this case the same treatment of ventilation and drainage produced almost immediate relief of distressing symptoms, and has been relieved till this time.

H. G., a small active boy, rather pale and undeveloped, with a definite respiratory history, was also relieved with treatment directed to his sinuses. X-ray and transillumination evidenced antrum infection, which was not confirmed with puncture. As stated above, he yielded to this treatment.

The technique of my treatment in these cases is to first cleanse the nose of all foreign matter and secretions, with alkaline sprays and suction, and then pack the region over and under the middle turbinate with cotton pledgets saturated with 10% argyrol (I might say here that other silver preparations have been as satisfactory). These packs are left in the nose for a period of one hour, after which time they are removed, and

*Read before the 53rd Annual Meeting of the Florida Medical Association, Gainesville, May, 1926.

negative pressure is again applied, and the increased secretions are entirely removed from the nasal cavities. As a matter of comfort to the patient a bland oil is next sprayed into the nose. This treatment is repeated daily, and as the secretions are reduced and symptoms lessened, the interim between treatments is increased, but the patient is kept under strict surveillance after the asthmatic attacks disappear.

This treatment has been carried on long enough to convince us that in a large number of cases these children are apparently relieved. I am in no position to quote statistics on account of the small number of cases I have accurate and complete data on. In no cases were the results disappointing. But even the relief of a few of this large class of hopelessly suffering children is encouraging enough for us to continue this work.

Dr. James H. Fellows:

Focal infection in children as in adults has explained many, heretofore, obscure conditions. It has only been in the past few years that sinus infection has received attention as a cause of bronchial asthma; while these infections are not as easily discovered in little ones as they are in adults, they can be located by keeping them in mind. The following cases of bronchial asthma that have been relieved through the treatment of infection in the nasal sinuses are offered as more evidence of what may be gained by locating these infections. I may add here that the food proteins had been run on these children, that their diets and general health had received careful attention, but not until the sinuses had been discovered and properly treated, did we get any real results.

Case No. 1—Joe G., age 14 years, breast fed, began having frequent attacks of bronchitis at 18 months, asthmatic attacks at 2 years, measles and whooping cough at 3 years, adenoids and tonsils removed at 6 years, again at 14 years; sinus found after the last adenoid and tonsil operation; drainage instituted. No return of asthma in last nine months.

Case No. 2—Herbert G., age 6 years, weight has been stationary for months, patient has had frequent colds since one year of age, severe attack of whooping cough at one year, measles and chicken pox at 4 years; all modifications of diet failed to produce gain in weight. Adenoids and tonsils removed at 3 years; began having attacks of asthma at 4 years; pus found in antrum 7 months ago; drainage instituted; patient has had two attacks of colds in the past four months, but did not have asthma, which is the first time this has occurred; has gained five pounds in the past three months. This patient was sensitive to horse hair; the mattress was removed, but had no effect on the asthma.

Case No. 3—Clarence P., age 6 years, measles and whooping cough at 4 years; adenoids and tonsils removed at beginning of attack of whooping cough two years ago; frequent attacks of asthma since. Patient was underweight, anemic, a poor sleeper, easy to take cold; pus located in the left antrum in 1925; drainage instituted; no return of asthma in past year; patient has gained several pounds in weight, eats and sleeps well.

Case No. 4—Mary H., age 4½ years, has not had any acute infections of childhood, frequent attacks of bronchitis, occasional attacks follicular tonsilitis; asthma began at 22 months, reacted to egg and milk; would average one and two spells of asthma every month; adenoids and tonsils removed at three years; temporary relief from asthma, three months; pus located in antrum three months ago; drainage instituted. Patient's condition improved remarkably, and has not had an attack of asthma in 5 months.

DISCUSSION.

Dr. A. H. Freeman, Ocala:

I think Dr. Lischkoff is to be complimented for his work along the line of this, to us, new field. Although thoroughly studied for the past fifty years, it has been doubted that there was any relation between the nose and bronchial asthma. It was considered for many years to be due to irritation from spurs, deviations of the septum and other pressure symptoms through reflexes. Today the opinion is one of a different viewpoint. The road of entrance of the poison, infection or what-not, from the nose in sinus cases to the lungs is an interesting one to me whether it goes through the lymphatics, as Dr. Lischkoff referred to in his excellent paper, whether it is a reflex, as the older men thought, or whether it is allergic as the newer schools are inclined to think—are just a few points on this subject. We know that over 50% of the cases of bronchial asthma are due to animal emanations, hair, feathers and the like. Also a large portion of these cases are due to plant pollens. Many are due to food, also allergic. The first

two groups, animal emanations and plant pollens are evidently inhaled through the nose. Whether that produces an irritation in the nose that causes the reflex, or whether pollens are absorbed is a problem. I believe they are absorbed. I think all these cases are allergic. We know the nasal mucous membrane absorbs drugs. If animal emanations and plant pollens inhaled through the nose produce an allergy why not the hyperplastic mucous membrane lining the nasal walls—why may not that be producing some substance that is likewise absorbed in the circulation, and assure an allergic reaction without the presence of bacteria?

Dr. Dennis of Colorado Springs, in reporting some fifty-odd cases two years ago, stated that very few of his cases showed little pus at any time anywhere, but the condition he met with when opening the sinus (and, by the way, the sinus that produced most of his cases was the antrum of Highmore) in some forty cases out of the fifty all he found was a hyperplasia, no pus. There is a relationship and we know it. But as to which of these is the method of entrance is yet to be solved. I believe it is allergic.

Then there is this point: Your pathology in the nose may be but a manifestation of your allergy. That has to be thought of.

I believe with Dr. Lischkoff that these cases should all be examined in every possible way for every source of cause. I think the skin test should be done in every case and any pathology in the nose should be corrected. If the nose is a well-drained nose there is a chance that you will have trouble from it, but much less than in the poorly drained nose.

Grant reports from Edinboro that the studies made more than two years ago show that the posterior and upper areas of the nose were the ones most potent in producing reflexes in the lung. So, if you have an obstructed case, look carefully in the upper and posterior areas of the nose. By the way, those of us who do that work know that the upper area of the nose is the one most often overlooked and yet the most important in our study of these cases with relation to asthma.

Dr. Clifton Moor, Tallahassee:

I think Dr. Lischkoff's paper is of particular interest from several viewpoints. First, it calls our attention to the importance of considering the possibility of paranasal sinus infection in children. In older people I don't think at this day and time that it is so often overlooked—in children it is. And I have no doubt that the condition of sinus infection in children occurs much more often than is recognized. The sinuses are of significance, that is some of them, in really very early life. Dean reports a positive ethmoidal infection demonstrated by operation in a child of one year. And very definite ethmoiditis in another case, the autopsy findings demonstrating a very virulent infection in the youngster at sixteen months. Now infection in the very young child is no doubt very often overlooked, and that perhaps explains a good many symptoms traceable or chargeable to focal infection and not relieved by tonsillectomies. In other words, rheumatic conditions and joint conditions which persist following tonsillectomy could no doubt be accounted for if an investigation of the sinuses be made.

Clinically some of the authors divide these cases into two groups: first, the typical bronchial asthma due to protein sensitization and following the rules of the allergic disease generally. In this group there may be sensitization to animal eliminations, pollens, feather dust, and whatever the cause may be, and they are classed definitely as typical bronchial asthmas. The second group (and I have no doubt that it makes up the largest percent of asthma cases in children) is the so-called atypical bronchial asthma or asthmatic bronchitis. In the first group there is a typical sensitization to a protein. In the second group there is a chronic infection as the basal cause, and whether the symptoms are an allergy of the bacterial protein or whether it is due to infection per se, I don't think any of us would state.

The work of Brochi, just mentioned, demonstrated that the use of foreign protein in the nasal passages produced an irritation through the bagus and constriction of the bronchi. This other group may not be typical allergies. However, they are of vast clinical interest, and I feel sure that if there is a closer cooperation between the pediatrician and the rhinologist, in the case which tonsillectomy is indicated and operated if that case is followed up, we will be able to find in quite a number of instances cases of sinus infection, which no doubt were due to nasal disease primarily and are not relieved by tonsillectomy; and that our cases would get more definite permanent results, and a great many cases that have been recurring would be definitely cured.

Dr. W. E. Ross, Jacksonville:

I did not hear this paper, but am very much interested in it.

As we all know, the younger child has practically one cell only where we find a greater number in adults. This cell is very small, and as a general thing in the young child I agree very emphatically with what Dr. Osincup said—that it is largely the turbinate bone. (My friends, the eye, ear, nose and throat men, would not agree with that.)

In my experience there has been one thing which has helped me more than anything else. If you will irrigate that child's nose with normal saline solution three times a day you will get away with things that you have never gotten away with any other means. That has been my experience. Now, the eye, ear, nose and throat men will tell you that this is absolutely and theoretically wrong. But if you can get the cooperation of the child and use a pint of normal saline solution run through that child's nostrils, back on one side and out on the other side, three times a day, you will get results, I think, that you have never been able to get in any other way.

I think the secret of not getting infection in the sinuses from that, is the fact that you get the forehead of the child lower than the chin. Get the child in a position with its forehead lower than the chin by leaning forward and you will have no trouble. The solution does not go into the eustachian tube, or that is my experience. I have had a number of cases of that type in the last year or so. And I have gone into all of them with that idea in view and have gotten results. I never have seen one yet have any trouble with the eustachian tube or middle ear from it. Neither have I seen one yet in which I did not get results. Just take normal saline solution and with an acorn tip fill up the nostril. You can soon get the cooperation of the child, and get results with them.

CONCLUSION.

Dr. M. A. Lischkoff, Pensacola:

I am glad that this paper brought out some discussion. One of the most important things is to get the cooperation of the rhinologist, or at least for the rhinologist to get the cooperation of the pediatrician.

As Dr. Freeman stated, by the use of animal dyes, India ink and other dyes these conditions would be seen all the way down to the terminal bronchi. Of course, we believe that this is an infection, but if it is bacterial proteins would use the same road. Now, in reference to protein emanations. Every one of these children was tested. They were tested during treatment, and during treatment developed protein sensitization, giving a reaction to eggs or milk. As they got better the reaction disappeared. So I contend that protein reaction is a secondary reaction or the result of nature's efforts to eliminate.

In most of our cases we did not find pus in the sinuses. My diagnosis was hyperplastic sinusitis, either of the ethmoid or maxillary sinus.

One of the gentlemen asked what would we do with these enlarged middle turbinates. While these cases begin first as a hyperplasia they continue, and if these children develop severe colds they get a mixed infection; then the infection remains in the sinus cavity. The cavity remains closed and there is no more drainage. If obstruction takes place, elimination is prevented and your bronchial asthma or asthmatic bronchitis, as you wish to call it, results. Now, with reference to the treatment: Some of you do not seem to understand. For a number of years I think it was Dowling of Albany, N. Y., used argyrol tampons in the nose, for treatment of hyperplastic sinusitis. I have been using them for a long time with very good results. Later on I began to use suction, but did not use the two together for a long time. I think this treatment is now being worked out with a view to using both. We first cleanse the nose by giving the patient an alkaline spray. After cleansing the nose we then put on negative pressure up to 20 lbs.—as a rule 8 to 10 will clean the secretions out of the nose—and then this area is packed with 10% solution of argyrol. This is left in for one hour and at the end of one hour the packs are removed. This removes most of the secretions, but if it continues, suction is again applied. We clean the sinuses out and then use a bland oil. If the patient goes home, we give them a 10% solution of neo-silvol to drop in the nose. They are instructed to lean the head back and drop this medicine in each nostril and then lean the head forward.

With reference to the saline solution spoken of by Dr. Ross: If he will use a nasal syphon he will find it just as easy, the patients will use them just as well and he can use saline or some

alkaline preparation and yet reduce the danger of eustachian infection.

Now, someone stated that so many are not relieved by tonsil and adenoid. The tonsil and adenoid operation as a rule is done after chronic pathology exists in the sinus, and the tonsil and adenoid only gives you a temporary drainage of these sinus cavities, and then after a while the drainage from the sinus is again obstructed.

EARLY PULMONARY TUBERCULOSIS RŒNTGENOLOGICALLY CONSIDERED*

H. O. Brown, M.D.

Clearwater.

This paper is purposed to be a discussion of the earliest indications of pulmonary tuberculosis that can be detected by rœntgenological examination. It is also an attempt to evaluate the relative weight of rœntgen diagnosis when used as an aid to clinical diagnosis. No claim of original observation is made as it is more of a compilation of the views of many as have been voiced during the period 1923-26.

Diagnosis of lung conditions is the most difficult field of rœntgenology and will only prove reliable after the examiner has had considerable experience and has had an opportunity of studying many cases both clinically and through serial rœntgenological study.

In any given case of pulmonary tuberculosis there is no clear rœntgenological indication of the exact duration of the disease process; therefore, rather than referring to a case as being "early" tuberculosis, it should be classed as minimal. The term incipient tuberculosis has also been discarded as this, too, has a time reference and any attempt to determine the length of time condition has existed would be mere speculation.

In pulmonary tuberculosis we know that the lymphatic system is the chief carrier, therefore a review of the pulmonary lymphatic system is important. In the normal lung the direction of the lymph flow generally is from periphery toward the hilus with exception of that tissue immediately adjacent to the pleura which is drained into the pleura and the lower third of each lower lobe where it travels directly across the surface of the diaphram and then up to the lower pole of the hilus.

The development of tubercules at point of lymphatic anastamosis blocks the normal flow and a reverse flow is established draining these tubercles toward the periphery. Thus the extension toward the periphery is explained.

The working theory of tuberculous involvement is in keeping with the above. It is supposed that tuberculosis occurs primarily during childhood and first attacks lymphoid tissue. In children of 12 years involvement is first noted at hilus and then later the pleura with very little if any parenchymal involvement. Recovery usually ensues and the individual has developed an immunity which protects until an overdose of infection is received or individual suffers a lowering of his immunity and is reinfected from his own focus. Here we see a second reversal of the lymphatic flow and the tendency is toward gradual parenchymal involvement with the apices, axilla and first two interspaces as the favorite sites.

The first change which we note is a shadow ½ to 1 c.m. in diameter which is caused by a tubercle plus pneumonic exudate. From this spot leading toward the hilus the bronchial trunk markings are wider than usual, especially after direct extension of the process has occurred from this new nidus. If the area is large enough or if the virulence of the organism is high the individual will consult a physician for certain clinical symptoms. Usually the tissue involved is too small and the virulence of the organism too low to cause clinical symptoms and the patient does not report for treatment until a greater involvement has occurred. In a large number of these cases the disease becomes arrested here and then follows the usual tubercle formation with final fibrosis and calcification.

Cases which have been clinically arrested for one month to one year will often show mottling of lung are aggregating 4 to 12 c.m. with one or both apices involved and areas presenting obvious signs of different ages and fibrous tissue contraction. The usual history in such cases is repeated attacks of grippe.

From the understanding of the mode of development we may draw three conclusions:

First: It requires more than an isolated bit of pathology to given symptoms unless infection is very virulent.

Second: Given a case presenting a very lim-

*Read before the Pinellas County Medical Society at Clearwater, Jan. 25, 1927.

ited amount of involvement in a region that is characteristic of tuberculosis with presence of fibrous tissue and calcium deposits, you may state positively that patient has or has had tuberculosis, but it is impossible to say that the clinical symptoms are due to that limited area of lung involvement.

Third: Given a case presenting typical symptoms of tuberculosis in which the lungs are clear rœntgenologically the proper inference is that those symptoms are not due to tuberculosis of the lungs.

Peribronchial tuberculosis, if it exists as an entity, cannot be diagnosed by X-ray. Dunham's Fan means nothing to the writer, as I have either never seen one or else I have seen it in every lung which I have examined.

From the second moral we see that the question of activity may only be suspected by the rœntgenologist but that a final determination must rest with the clinician or by serial rœntgen examinations.

At the outset we must admit that before active pulmonary tuberculosis can be diagnosed with certainty upon a single rœntgenological examination rather extensive typical involvement must be present. Frank S. Bissell of Minneapolis, in this connection, aptly states, "Paradoxical though it seems, it is believed to be a fact that there is a higher percentage of error in rœntgen diagnosis of advanced tuberculosis than in the earlier lesions. This is because the lesions which simulate tuberculosis most closely are usually gross in character and involve large lung areas. The following conditions may be cited as examples: Pneumoconiosis; Hodgkin's disease, infiltrating type and metastatic carcinoma." These mistakes can only be avoided by working in collaboration with the internist and the possession of a clear history of the case. E. G. Pneumoconiosis, history.

Not only is it important that the rœntgenologist be familiar with the history of the case but he should also see the patient and personally make a careful fluoroscopic examination to ascertain the adequacy of areation of apices and the range of diaphram movement. In many large X-ray laboratories, technicians do all rœntgenographic work and the rœntgenologist sees only the finished films with possibly a few history notes. We are dealing with shadows only and these shadows mean nothing unless they can be visualized as definite pathological processes which can be reconciled with the physical findings and case history.

If a knowledge of the case history is important in advanced tuberculosis, is it not more important in cases of limited involvement?

The diagnosis is easy in a case in which all of the following conditions can be visualized:

1. Discrete mottling in upper lobes.
2. Fibrous tissue causing distortion of trachea, displacement of heart and narrowing of interspaces not to be explained by spine deformity.
3. Calcium deposits, parenchymal.
4. Cavitation in upper lobes or elsewhere.

In the absence of a definitely suspicious history all of the above excepting cavitation must be noted before a positive label can be appended from a single examination. There are cases in which the initial involvement is basal and these cases offer considerable difficulty in diagnosing especially when cavitation is met. Here only considerable experience and serial examination will permit a trustworthy diagnosis. Happily the base is not the favorite location of early tuberculosis, but it does occur often enough to justify consideration.

The present accepted classification of pulmonary tuberculosis from both a clinical and X-ray standpoint is as follows: Minimal, moderately advanced, and far advanced. Each class offers definite clinical and rœntgenological limitations.

X-ray findings in minimal tuberculosis show a total area (parenchymatous) involved not greater than to the upper level of the second chondrosternal junction on one side with one or both sides showing some involvement. This involvement to be in the form of scattered mottling or an intense shadow interpreted as pleuritic.

Mottling is the earliest sign which can be definitely diagnosed and is characterized by numerous various sized transparent or translucent spots with ill-defined margins, usually fusing with one another; or the small spots may be scattered and discreet, though usually they have a feathery margin and tend to fuse with the surrounding shadows. The term mottling is not to be used to describe isolated small densities which can almost be counted. Mottling is the appearance given by numerous small tubercles.

Intense shadows describe an area or areas of an interspace or more of almost transparency. This is to be either intra-pulmonary or differentiated from pleuritic changes which also cast an intense shadow. The mammæ, the pectorals, the

sterno-cleido-mastoid are often confusing but may be differentiated by proper technique. The character of an intense shadow is about like that cast by the heart.

From a clinical standpoint, Lawreson Brown, Heise and Sampson define minimal tuberculosis as embracing the following:

1. Slight or no constitutional symptoms (including gastric and intestinal disturbances or rapid loss of weight). These slight disturbances refer to slight loss of appetite, of strength, of weight and a lassitude. Impairment of health may be so slight that the patient does not look or feel sick in the ordinary sense of the word.

2. Slight or no elevation of temperature or acceleration of pulse at any time during the 24 hours. This includes a maximum temperature after a rest of one hour, never above 99.5 to 100 Farh. by mouth or 100.5 by rectum. The pulse not to be over 90 after one hour rest, sitting or lying, except when due to other causes than tuberculosis.

3. Expectoration usually small in amount or absent.

4. Tubercle bacilli may be present or absent.

5. Slight infiltration limited to apex of one or both lungs or a small part of one lobe. This producing a slight narrowing of apical resonance with lessened movement of bases of lungs; distant, loud or harsh breathing; some moisture which persists after coughing and increased vocal fremitus. Prominence of clavicles usually noted.

6. No tuberculous complications.

It is readily seen that the rœntgen findings in this type of case are few and give no positive indication as to activity or quiescence. Therefor it is absolutely necessary to treat these findings as only partial evidence in arriving at a diagnosis. Should the case show the clinical and physical manifestations of minimal tuberculosis then we can say there is tuberculosis present and that it is not quiescent. The degree of activity can be ascertained only after the exclusion by physical examination of other disease processes; the progression of physical signs as elicited by frequent examination and by rœntgen reexamination at monthly or bi-monthly intervals.

A case seen by me last summer demonstrated the importance of not relying upon a single physical or single X-ray examination to determine activity. This case gave the history of a persistent cough, non-productive, following a cold taken one month before. Moderate night sweating was noted. Weight was being maintained and there was no loss or impairment of appetite. Lassitude was evident. Physical signs were few, the only findings being harsh apical breathing, subnormal morning temperature with normal afternoon temperature and a pulse of 90. Sputum was negative on several examinations. The abundance of calcium in the upper lobe was interpreted to mean a healed process and only slight mottling could be detected. A tentative diagnosis of quiescent minimal tuberculosis was made and no recrudescence was anticipated. However, within one month the cough became aggravated and hemoptysis occurred. A second set of stereoscopic rœntgenograms revealed a small cavity in left first interspace from which hemorrhage probably occurred. Under ordinary care this patient now, four months later, is symptom free, has no cough and has gained 20 pounds. Should hemoptysis not have occurred early as it did in this case, this patient would probably have progressed much further before a second X-ray would have been deemed necessary and the diagnosis and treatment unnecessarily delayed.

Rœntgen diagnosis of lung conditions is rapidly coming into its own so far as popular favor and confidence is concerned. In 1922 The Diagnostic Standards of the National Tuberculosis Association included in its minimum standards for diagnosis of pulmonary tuberculosis the statement, "X-ray evidence of apical infiltration may be important." The new volume now states: "It is now recognized that the proper taking of X-rays, preferably stereoscopic, is an essential procedure in examination of the chest." It also recognizes the fact that definite parenchymal changes are seen in nearly all cases of proven pulmonary tuberculosis, the exception being in some sputum positive cases from caseous hilus glands and then a fairly diagnostic feature will be noted on the film. In many sanatoria rœntgen evidence is relied upon to determine resolution of lesions in preference to physical methods and many cases are proven cured even though patient continues to present apical rales after the disappearance of clinical manifestations of activity.

We know that resolution even of extensive caseous tuberculosis with cavitation can and does often entirely disappear under treatment; that

extensive tuberculosis of the inflammatory or exudative type may entirely disappear; that the majority of localized exudative lesions clear up entirely. Is it not then important to know the progress of each case just as much as it is to arrive at the original diagnosis? This is particularly true when home or expectant treatment is used, as it is much safer to have an X-ray control than to depend upon physical findings alone. In sanatoria where every facility for the recording of each change in the patient's condition is available, they have the added satisfaction of proving their findings in serial X-ray examinations.

Many cases of minimal pulmonary tuberculosis existing before pregnancy go unrecognized until during the latter months when the overtaxed lungs succumb as a result of lowered resistance, limitation of air space and the increased demands placed upon them. Active pulmonary tuberculosis is a definite indication for a therapeutic abortion. Would it not be a wise procedure to ray all early pregnancies that have a suspicious history or suggestive lung findings.

SUMMARY.

1. X-ray is a trustworthy measure in chest examination, offering evidence which is unobtainable in other ways.

2. Serial examinations are indicated in both arriving at the diagnosis and during the course of treatment as a check.

3. Clinical history is just as important to the rœntgenologist as to the internist or surgeon unless the opinion of the rœntgenologist is not wanted.

A CASE OF TETANUS

WILLIAM H. WATTERS, A.M., M. D.,

Miami.

The following case is briefly reported, not because it is of unusual rarity but in order to give emphasis to the need of one form of preventive medicine that is too often overlooked, and to show how a very simple procedure would have forestalled a large amount of suffering and almost imminent death.

Robert W., age four years, was brought in an automobile by his parents with the following history. He had been in apparent good health all his life as far as known. About three weeks ago while playing in the garden of his home he had been accidentally struck on the head by a small shovel in the hands of an older brother. He received a small but deep cut in the right parietal region which bled but little. His mother treated this with iodine immediately and on the following day took him to see her family physician. The doctor examined the wound, found it already well covered with a scab and assured the mother that there would be no further developments. Healing continued in an uncomplicated manner. In about twelve days he developed restlessness and nervousness. On the fourteenth day strabismus appeared and became steadily worse. Then came progressive stiffness of the jaws, rigidity of the muscles of the neck and convulsive movements of the muscles of the back and arms.

When seen he had a temperature of 100° F., pulse 110 and respiration 18. The jaws were almost completely closed, swallowing of solids being impossible, while liquid could be taken in very small amounts and with great difficulty. The posterior muscles of the head and neck were rigid, producing distinct opisthotonos. Frequent convulsive twitchings involved practically all the muscles of the back, arms and legs. These continued and increased in severity, occurring both when the child was awake and when he was asleep. The scalp wound was firmly healed and measured 2 cm. in length. Pupils dilated and react to light sluggishly. Heart and lungs negative. Reflexes hyperactive. Urine shows trace of sugar and occasional hyaline cast. Blood hæmoglobin 80%, leucocytes 10,500, neutrophiles 76% spinal fluid, cell count 3, globulin negative. Wassermann negative, colloidal gold 3,443,333,-210.

A very discouraging prognosis was given the parents and treatment immediately begun. This consisted of the intravenous administration of 10,000 units of antitetanic serum immediately followed by an equal amount given intraspinally after 25 c.c. of clear spinal fluid under much increased pressure was removed. At 6 p. m. the temperature was 104.6° F., the pulse 120 and the respirations 40. During the night there was no material change but no increased prominence of the symptoms that had up to that time been steadily increasing in severity. The following morning the antitoxin treatment of the preceding day was repeated in the same amount, 30 c.c. of spinal fluid under less pressure was removed but with a distinctly turbid appearance. Examina-

tion showed a cell count of 1,310. Direct smears and various cultures for bacteria gave uniformly negative results.

The following day also the scar on the scalp was excised under light anæsthesia. During the afternoon following the second treatment there seemed to be some decrease in the severity and frequency of the convulsions and during the night sleep was distinctly less interrupted by these attacks. On the third day the intraspinous treatment only was given. Here 27 c.c. of less turbid fluid under less pressure was removed. Cell count 610. All tests for bacteria negative.

The muscle rigidity is now slowly decreasing, the convulsions are less frequent and the jaws can be opened a little wider.

Fourth day 10,000 units antitoxin intraspinous. Removed 30 c.c. fluid, cell count 140, no bacteria, colloidal gold 1,122,210,000.

Fifth day, 10,000 units intraspinous.

Seventh day, 10,000 units intraspinous, cell count 35.

There was a steady subsidence of all symptoms until on about the seventh day when the boy had practically returned to normal. Convalescence continued in an uninterrupted manner except for a slight respiratory infection in the second week lasting for two or three days.

The case seems worthy of note for three reasons:

First, it illustrates the importance of not permitting to go unheeded conditions that are apparently of no serious import. This is particularly true of deep, slightly bleeding wounds made by implements liable to be carrying tetanus containing material, of which garden earth is notorious. It is extremely probable that if the doctor who first saw this boy had administered a prophylactic dose of tetanus antitoxin and repeated it in a week no symptoms of the disease would have ever appeared.

Second, many authorities state that tetanus becomes more rapid in development and serious in prognosis the nearer the point of infection is to the brain. In this case the site of inoculation was undoubtedly the scalp where a very serious prognosis was fully justified. Nevertheless by use of large doses of antitoxin and possibly by excision of the original focus a steady improvement going on to complete convalescence was brought about.

Was this due merely to a neutralization of the toxin in the blood by the antitoxin or did the latter actually prove efficient to break up the strong affinity known to exist between the tetanus toxin and the central nervous system? Who can say?

Third. This might be termed a by-product. It will be noted that the first spinal fluid examination showed a cell count of 3, while the second made twenty-four hours later after intravenous injection was 1,310.

I well remember some years previous the first time I had encountered this phenomenon where after the intravenous injection the cell count rose from 5 to 5,000 in a day. Visions of a post-operative acute meningitis were unpleasantly vivid even though unaccompanied by other symptoms of the disease. Later experience has shown the change to be no longer a cause of fear but to be recognized as a probable reaction of the meninges to the first introduction of a foreign body protein or otherwise with more or less irritant qualities.

It here, as in other cases, steadily returned to normal even during persistence of the intraspinous treatment.

EXTRAGENITAL CHANCRE

C. F. Roche, M.D.,
and
Thomas B. Hall, M.D.,
Miami Beach.

The following case report is presented for two reasons: First because of the rather bizarre location of the primary lesion and second on account of the rather interesting history in connection thereof.

Patient, F. P. M., applied for treatment on December 15th, reporting as his chief complaint an acute external thrombotic hemorrhoid. The few brief notes of the patient's history are as follows:

Age, 47; usual diseases of childhood; typhoid in 1898, contracted during the Spanish-American war; married at the age of 27; divorced from his wife since 1917; wife had no children and no miscarriages. Patient admits Neisserian infection in 1899 and was said to have been cured in five months. Denies any luetic history. Patient has had protruding piles periodically for the past ten years. One hemorrhoid, he states, became unusually large about October 16, 1926, causing

considerable pain and tenderness which necessitated his leaving his position as houseman at one of the local hotels. Examination of hemorrhoid showed one of the acute thrombotic type, oval in shape and about the size of a pigeon egg. On the inner surface of the tumor near the anal margin was a shallow erosion which suggested the possibility of irritation from toilet paper. Following draining of the tumor mass this eroded area was treated with a ten per cent solution of silver nitrate. The following day, in making a similar application, it was observed that the edges of the erosion were very hard and indurated. The patient was directed to the laboratory immediately for a dark field examination and Wassermann, both of which were subsequently reported as positive. Further questioning of the patient with a view of determining a possibility of sodomy having occurred, elicited the following rather interesting story: In September, 1926, following the storm, patient's food supply became very irregular and uncertain, resulting in his becoming markedly constipated. This condition would not yield to the usual type of cathartics and he conceived the idea of borrowing a douche bag from the room of one of the female employees of the hotel. He claims to have used this on three different occasions. He also volunteered the information that he had definite knowledge that the woman who owned the bag was of questionable character.

The day following the report of the positive findings in the dark field illumination, the patient disclosed a generalized roseola and marked adenopathy.

His condition promptly cleared up following the prompt administration of appropriate antiluetic treatment.

The Palm Beaches Await the Annual Meeting of the Florida Medical Association

Jane Floyd Buck,
West Palm Beach.

When members of the Florida Medical Association gather in the Palm Beaches for their fifty-fourth annual meeting in April they will find the sister resorts wearing their fairest garb, and prepared to give the visitors a convention that will go down in the annals of the association as a criterion for future meetings.

Activities for the entertainment of the visitors have been under way since January and plans already are complete for a program of interesting events that will be staged in the most beautiful spots these resorts—renowned on both continents for their fairy-like charm—have to offer. And already it is evident that keen interest in this year's convention city will bring the greatest gathering of physicians the state meeting ever has assembled.

Developing by leaps and bounds, with a luxuriant rapidity most aptly likened to the exuberant growth of the vivid tropical flowers that flame into color wherever the eye turns, the Palm Beaches have now everything that imagination may create or heart desire for the fortunate visitor to their palm-shaded shores.

Of West Palm Beach it may be said that she has reached the dignity of a most modern city, yet has kept the charm of the resort where pleasure and diversion are foremost considerations. Standing proudly on the shores of Lake Worth, West Palm Beach now lifts a sky line that might be envied by a city of several times her present healthy population of 50,000. The lately opened ten-story Comeau building, erected at a cost of more than half a million dollars, silhouettes its stories against a sky that dazzles with its blueness. The $750,000 Harvey building, now nearing completion, will rear its height to fourteen stories, and the new Pennsylvania hotel, with its broad balconies overhanging the shores of Lake Worth, represents an investment of $825,000, while the new home of the Farmers Bank & Trust Company—considered one of the most beautiful banking institutions south of New York—has frequently been called a cathedral of finance, so costly and artistic is the architecture.

Crossing the sparkling expanse of Lake Worth, one gains the shores of Palm Beach, a veritable fairyland with its beautifully planned avenues, shaded by stately royal palms intermingled with every variety of tropical shrub, its marvelous



El Verano Hotel, Convention Headquarters

estates, its gleaming beach with the waters of the Atlantic rolling in like waves of melted sapphire, so brilliantly blue is the ocean here and so unbelievably clear.

It would not be possible to tell in so short a space of the many wonderful hotels, tea gardens and clubs created for the pleasure of the thousands of winter visitors who spend happy weeks



Business Street, West Palm Beach



West Palm Beach Sky Line

and months in the Palm Beaches every season. One of the memorable meccas for lovers of architecture and landscaping is the magnificent new Breakers hotel, built at a cost of $7,000,000 and opened this past December. With the furnishings and decorations a symphony of beauty to delight the eye of the connoisseur, the Breakers stands supreme. Then there is the famous



Tea Garden, Palm Beach



Lake Worth, Palm Beach

old Poinciana with its unrivalled tea garden where gay crowds dance every afternoon under the crooning coconut palms. Whitehall, another gem of architectural beauty on the shores of Lake Worth, the Alba with its air of old-world elegance, that houses within its stately walls priceless tapestries, pieces of rare furniture and objects of art gathered from every corner of Spain. Just around the corner from the Alba one finds the spreading white expanse of Bradley's, America's Monte Carlo, the club of clubs, around whose tables nightly are found the elite of two continents and where fortunes are won and lost on the turn of the wheel. The exotic Beaux Arts building, filled with shops that house bits of loveliness ranging from old silver to shoes, the New Palm Beach hotel with its roof garden affording exhilarating glimpses of the sparkling Atlantic, the Royal Daneli with its gay Venetian Garden, filled every night with a



Good Samaritan Hospital, West Palm Beach

throng, among whom are noted celebrities in the world of art, letters and the theatre. The Everglades Club, with its golf course that draws enthusiasts from every part of the country, and its enchanting open-air patio, where one dines and dances under the stars. These are but a few of the many diversions that Palm Beach holds out to her visitors with lavish hands.

Turning again to definite convention plans, the beautiful hotel El Verano, with its rooms and great dining hall overlooking Lake Worth, has been chosen as headquarters for the meeting, and the opening smoker, so inseparable to a successful convention, will be held in the Palm Beach Yacht Club, already famous for its annual regattas when sport devotees bring their craft from all parts of the United States to compete for honors. This beautiful club, too, stands on the shores of Lake Worth and will form a perfect setting for the first entertainment.

Of equal interest to the plans made for the visiting physicians, are those made for the wives, mothers and daughters who will accompany them. Every minute of the time will be filled with some attractive entertainment, so that they may be given an opportunity to know the charms of America's most famous resort at its fullest.

While this description of what the Palm Beaches will offer their visitors when they gather here in April is so brief as to be merely en silhouette, members of the local society feel that when the fifty-fourth convention has become history, their brother practitioners from other parts of Florida, whether they have visited the convention city before or not, will know the charms of their state more intimately and deeper bonds of friendship will have been established.

AN INVITATION.

THE PALM BEACH COUNTY MEDICAL SOCIETY WILL ACT AS HOST TO ALL MEMBERS, GUESTS AND THEIR LADIES AT THE ANNUAL BANQUET TO BE HELD TUESDAY EVENING, 8 P.M. THE NEW PALM BEACH HOTEL WILL STAY OPEN FOR THIS OCCASION.



Convention Headquarters.

PROGRAM

of the

FIFTY-FOURTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT WEST PALM BEACH, FLORIDA

APRIL 5th and 6th, 1927

INFORMATION

Information desk will be located in the lobby of the El Verano Hotel with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are requested to register. Tickets for the banquet, Tuesday, April 5th, may be obtained at the registration desk.

PROGRAM OF ENTERTAINMENT

Monday evening, April 4th, 8 p.m.—Smoker at the Palm Beach Yacht Club given by the Palm Beach County Medical Society.

Tuesday evening, April 5th, 8 p. m.—Banquet (Palm Beach County Medical Society, Host) at the New Palm Beach Hotel for members and guests. Dance follows banquet in ballroom of New Palm Beach Hotel, beginning at 10 p. m.

Wednesday, April 6th, 8 p. m.—Banquet, Golf Association, at Palm Beach Yacht Club.

ENTERTAINMENT FOR LADIES

Monday, April 4th.

10:00 a. m. Automobile drive followed by swim at Casino.
8:00 p. m. Musicale, El Verano Hotel.

Tuesday, April 5th.

9:30 a. m. Business Meeting, Woman's Auxiliary, West Palm Beach Woman's Club.
1:00 p. m. Luncheon, Palm Beach Hotel.
2:30 p. m. Boat trip on Lake Worth.
8:00 p. m. Banquet, followed by dance at the New Palm Beach Hotel.

Wednesday, April 6th.

Golf at the West Palm Beach Country Club.

HOTELS

Salt Air Hotel	Single, $3.00. Double, $5.00.
Hotel Monterey	$2.00 to $2.50.
Hotel Pennsylvania	Single, $3.00. Double, $5.00.
Dixie Court Hotel	Single, $3.50. Double, $5.00.
Royal Palm Hotel	Single, $3.00. Double, $5.00.
Alhambra Apartment Hotel	Single, $2.50. Double, $4.00.
El Verano Hotel	Single, $3.00 to $7.00. Double, $5.50 to $11.00.

COMMERCIAL EXHIBITS

Commercial Exhibits will be located in booths on the main floor and the mezzanine floor of the El Verano Hotel at the entrance of the Convention Hall.

LOCAL COMMITTEE ON ARRANGEMENTS

W. E. VAN LANDINGHAM, *Chairman*

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W. J. Buck
W. W. George
G. W. Heath
R. G. Lewis
L. M. Rozier
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Mrs. W. H. Gardner
Mrs. B. S. Clay
Dr. Alice R. Miller
Dr. Grace E. Papot

GENERAL MEETING OF THE ASSOCIATION

APRIL 5TH, 9 A. M.

Call to order by W. E. Van Landingham, Chairman of Committee on Local Arrangements.

Opening Prayer by Father F. J. Clarkson.

Address of Welcome, Mr. George R. Bensel, President Greater Palm Beach Chamber of Commerce.

Response, H. Marshall Taylor, Jacksonville.

Announcements.

Address of President, H. Mason Smith, Tampa.

SCIENTIFIC ASSEMBLY

Committee on Scientific Work: W. H. Spiers, Chairman; Harold D. Van Schaick, G. Raap.

Attention is called to the following By-Laws:

"All papers read before the Society shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orators, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, nor more than once on any one subject."

1. LEWELLYS F. BARKER, Baltimore, Md., (by invitation).
2. "Mechanical Aids in Estimating Cardiac Reserve." HERBERT CALDWELL, Lake City.
3. "Treatment of Cardio Vascular Diseases." MEREDITH MALLORY, Orlando.

Joint discussion:

Stanley Erwin, Jacksonville.
E. W. Bitzer, Tampa.
C. M. Tyre, Eustis.

GENERAL MEETING OF THE ASSOCIATION

April 5th, 12:15 p. m.

President in the Chair.

Report of Officers:

Secretary-Treasurer-Editor, Shaler Richardson.

Executive Committee, Gerry R. Holden.

Committee on Legislation and Public Policy, W. M. Rowlett.

Hospital and Medical Educational Committee, J. S. Helms.

SCIENTIFIC ASSEMBLY

April 5th, 2 p. m.

4. "The Rational of Roentgen Ray Therapy in Dermatology."
E. D. French, Miami.
Discussion: J. L. Kirby-Smith, Jacksonville.
F. A. Copp, Orlando.

5. "Deep Roentgen Therapy."
H. B. McEuen, Jacksonville.
Discussion: J. C. Dickinson, Tampa.
C. J. Marshall, Sanford.

6. "Congenital Hypertrophic Pyloric Stenosis."
J. W. Snyder, Miami.
Discussion: J. S. McEwan, Orlando.
V. D. Stone, West Palm Beach.

7. "The Care of the Patient Before Operation."
A. P. Roope, St. Petersburg.
8. "Post-Operative Care of Abdominal Cases."
J. C. Nowling, Ft. Myers.
Joint discussion: Joseph Halton, Sarasota.
R. M. Harris, Miami.

9. "Chronic Duodenal Ileus."
T. Z. Cason and J. A. Beals, Jacksonville.
Discussion: F. W. Foxworthy, Miami.
W. C. Thomas, Gainesville.

10. "Caesarean Section."
R. A. Ely, Tampa.
Discussion: Herman Watson, Lakeland.
E. G. Peek, Ocala.
H. C. Dozier, Ocala.

MEETING OF HOUSE OF DELEGATES

April 5th, 5 p. m.

SCIENTIFIC ASSEMBLY

April 6th, 9 a. m.

11. "The Relief of Pain."
Ralph Greene, Jacksonville.
Discussion: H. Mason Smith, Tampa.
J. Q. Folmer, Chattahoochee.

12. "Ureteral Stricture as an Etiological Factor in Kidney Disease."
Cayetano Panettiere, Miami Beach.
13. "Urinary Obstruction from Contracture of Vesical Orifice."
E. Clay Shaw, Miami.
Joint discussion: John E. Hall, West Palm Beach.
Herbert Snyder, Pensacola.

14. "Surgery of Male Perinium."
A. R. Knauf, Tampa.
Discussion: Maurice Heck, De Land.
T. H. Bates, Lake City.

15. "Bismuth as an Antisyphilitic Medicament."
Milton M. Coplan, Miami.
Discussion: J. C. Davis, Quincy.
H. S. Geiger, Kissimmee.

16. "Caudal Block Anesthesia—A Report of 114 Cases."
Leigh F. Robinson, Ft. Lauderdale.
Discussion: J. N. Fogarty, St. Augustine.
H. D. Clark, Ft. Pierce.

17. "Roentgenological Examination of the Upper Abdomen."
F. K. Herpel, West Palm Beach.
Discussion: G. Raap, Miami.
W. E. Whitlock, High Springs.

18. "Nephritis."
S. A. Folsom, Orlando.
Discussion: H. H. Harris, Jacksonville.
A. E. Conter, Apalachicola.

19. "Dairying and Its Relation to Preventive Medicine."
J. G. DuPuis, Miami.
Discussion: B. L. Arms, Jacksonville.

GENERAL MEETING OF ASSOCIATION

April 6th, 12 Noon

The President in the Chair.
Annual election of Officers.
Adjournment for Lunch.

SCIENTIFIC ASSEMBLY

April 6, 2 p. m.

20. "The Tonsil as a Primary Focus of Infection."
Peter Herman, West Palm Beach.
Discussion: J. L. Boone, Jacksonville.
R. D. Ferguson, Titusville.

21. "Why the General Practitioner Should be Familiar with the Anatomy and Pathology of the Mastoid and Petrous Portions of the Temporal Bone."
Jas. B. Parramore, Jacksonville.
Discussion: B. Palmer, Miami.
T. H. Odeneal, West Palm Beach.

22. "Gunshot Wounds of the Rectum."
L. A. Peek, West Palm Beach.
Discussion: Frederick Bowen, Jacksonville.
N. A. Baltzell, Marianna.

23. "Normal Diets for Diabetics."
Arthur Walters, Miami Beach.
Discussion: N. L. Spengler, Tampa.
R. H. Mooty, Winter Haven.

24. "Acidosis in Infancy."
Howard Bucknell, St. Petersburg.
Discussion: L. W. Holloway, Jacksonville.
W. E. Sinclair, Orlando.

25. "Significance of Recurrent Vomiting or the So-Called 'Bilious Attacks in Children'."
Geo. L. Cook, Tampa.
Discussion: W. C. Payne, Pensacola.
E. Clifton Moor, Tallahassee.

The annual meeting of the Florida Railway Surgeons' Association will be held in West Palm Beach, Monday, April 4th. The program will be announced later.

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Okalaosa, Walton, Santa Rosa, Escambia.
SECOND DISTRICT—DR. J. C. DAVIS, JR. *Quincy*
Liberty, Gadsden, Jefferson, Wakulla, Leon, Franklin.
THIRD DISTRICT—DR. L. M. ANDERSON *Lake City*
Hamilton, Dixie, Taylor, Madison, Columbia, Suwannee, Lafayette.
FOURTH DISTRICT—DR. LUTHER W. HOLLOWAY . *Jacksonville*
Nassau, Clay, Duval, St. Johns.
FIFTH DISTRICT—DR. H. C. DOZIER *Ocala*
Citrus, Marion.
SIXTH DISTRICT—DR. C. A. WILLIAMS *St. Petersburg*
Pinellas.
SEVENTH DISTRICT—DR. M. E. HECK *DeLand*
Brevard, Volusia, Seminole.
EIGHTH DISTRICT—DR. G. C. TILLMAN *Gainesville*
Putnam, Levy, Baker, Bradford, Union, Flagler, Alachua.
NINTH DISTRICT—DR. W. J. BLACKSHEAR . . . *Panama City*
Holmes, Washington, Bay.
TENTH DISTRICT—DR. HERMAN WATSON *Lakeland*
Polk.
ELEVENTH DISTRICT—DR. J. G. DUPUIS . . . *Leman City*
Dade.
TWELFTH DISTRICT—DR. BAKER WHISNANT . . . *Fort Myers*
Glades, Charlatte, Hendry, Lee, Collier.
THIRTEENTH DISTRICT—DR. R. C. HUBBARD . . . *Tampa*
Hillsborough, Hernando, Pasco.
FOURTEENTH DISTRICT—DR. N. A. BALTZELL . . . *Marianna*
Calhoun, Jackson, Gulf.
FIFTEENTH DISTRICT—DR. JOHN E. HALL . *West Palm Beach*
Palm Beach, Broward.
SIXTEENTH DISTRICT—DR. M. M. HANNUM *Eustis*
Sumter, Lake.
SEVENTEENTH DISTRICT—DR. JOHN S. McEWAN . *Orlando*
Osceola, Orange.
EIGHTEENTH DISTRICT—DR. S. G. HOLLINGSWORTH . *Bradentan*
Manatee, Sarasota.
NINETEENTH DISTRICT—DR. D. L. McSWAIN . . . *Arcadia*
DeSota, Hardee, Highlands.
TWENTIETH DISTRICT—DR. WM. R. WARREN . . . *Key West*
Monroe.
TWENTY-FIRST DISTRICT—DR. ROBT. C. BOOTHE . *Fort Pierce*
St. Lucie, Okeechobee, Indian River, Martin.

THE WEST PALM BEACH MEETING

This issue of the Journal contains the scientific program for our next annual meeting to be held in West Palm Beach April 5th and 6th. The program shows a diversity of subjects and will be of interest to both general practitioners and specialists. The Scientific Program Committee had over sixty applications for places on the program and many excellent papers could not be given a place. This is regrettable but demonstrates the keen interest that the members of the Association are taking in our annual meeting.

Also, we are publishing the program of entertainment which promises to be the most pleasing we have ever had. The West Palm Beach County Medical Society is bending every effort to make our meeting a great success and all of our members are urged to attend.

Most of the resort hotels will be open at the time our meeting is held and it will be a wonderful opportunity for our members to see and enjoy the splendors of the Palm Beaches' palatial hostelries.

THE MEDICAL CONFERENCE

At the invitation of our president, Dr. H. Mason Smith, the officers, committees and councillors of the Florida Medical Association met in joint session with the State Board of Medical Examiners and members of the State Board of Health on February 8th at the George Washington Hotel in Jacksonville. Mr. A .T. Stewart of Tampa, attorney for the State Board of Medical Examiners, presented a proposed new medical practice act for the approval of the meeting. As yet a copy of this new act has not been furnished the Journal for publication, but it is hoped in the very near future we may have the liberty of publishing it.

At the meeting of the councillors, reports were heard from fourteen districts, all of which showed much progress in the development of the various county medical societies. The councillors showed enthusiasm in their work and it is through this medium that the state association membership is being increased.

The Scientific Program Committee reviewed some sixty applications for places on the scientific program and selected twenty-four most excellent papers which will constitute the scientific work of our annual meeting to be held next month.

REPORTS OF COUNCILLORS AT MEDICAL CONFERENCE, FEBRUARY 8th, JACKSONVILLE

FIRST DISTRICT—Dr. W. C. Payne . . . *Pensacola*
Okaloosa, Walton, Santa Rosa, Escambia.

For many years Escambia has had a functioning society. On account of the small number of physicians in the other three counties, at times there has been no organized society. Four years ago, I met with the physicians of Walton and Okaloosa and they combined their forces into a bi-county society and it has been functioning since that time. There are only seven eligible doctors in Santa Rosa, and it was found impractical to have a society there. In 1926 I introduced a motion before the Escambia County Society, and it was voted favorably, inviting these seven doctors to join the Escambia County Society. Three have accepted the invitation and we have the application of three others to be voted on at next meeting. In September of 1926 I accompanied Dr. H. Mason Smith as president of the State Association, on an official visit to the societies in my district. After a careful survey, we recommended that the bi-county society of Walton and Okaloosa join the Escambia County Society as the Santa Rosa doctors had done. The Escambia County Society followed the suggestion by inviting these men to join. At a meeting of the Walton-Okaloosa Society, held in De Funiak Springs on January 20, 1927, it was decided by that society, however, that its best interests would be served by continuing its existence as a separate organization. They elected officers at this meeting for the coming year. I am informed by the secretary of the society that all except two eligible doctors in Walton and Okaloosa counties are members. In Escambia all eligible doctors except one are members of the Escambia County Medical Society. This is a good man and was a member, but was dropped on account of non-payment of dues. This was done only after every possible means were used in an effort to persuade him to pay up. To sum up, there are only five eligible men in my four counties who are not members of the Florida Medical Association, and there is more interest manifest in organized medicine now than has ever been in my thirteen years of residence here.

SECOND DISTRICT—Dr. J. C. Davis, Jr.....*Quincy*
Liberty, Gadsden, Jefferson, Wakulla, Leon, Franklin.
No report.

THIRD DISTRICT—Dr. L. M. Anderson . . *Lake City*
Hamilton, Dixie, Taylor, Madison, Columbia, Suwannee, Lafayette.

On December 2d, in company with Dr. Shaler Richardson, Dr. Stewart G. Thompson and Dr. L. J. Arnold, I visited a number of physicians personally—Lake City, nine; Madison, three; White Springs, two, Jasper, one; Jennings, one; Live Oak, two—total, eighteen. On the eligible list for invitations to the banquet given by the Columbia County Medical Society, December 13th, there was found to be a total of thirty-two. Total miles traveled over the district, one hundred twenty.

This covers the record of the first visit over this part of my district. It was certainly a pleasure to have had in my company Dr. Richardson, Dr. Thompson and Dr. Arnold.

Second Visit, January 27, 1927

Went to Perry in company of Dr. L. J. Arnold and found Perry one hundred per cent organized, with a regular society meeting and a good program every month. Two visiting physicians from Thomasville were there, but, owing to repairs on the road, which caused us to travel forty miles out of the way, arrived late. Coming back through Live Oak we visited a number of physicians and Dr. Arnold enrolled three doctors who paid their dues—Dr. White, Dr. Price and Dr. Kirkland.

I herewith report, from the Columbia County Medical Society, thirteen members one hundred per cent dues paid. Out of seventeen physicians in the county—one retired—only two are not associated with the Columbia County Society. Several doctors that we visited, residing in this county, have not yet seen fit to join. Total number of miles traveled, three hundred nine. Every doctor, or his office, in my district was visited personally by me.

I wish to thank Dr. Richardson, Dr. Thompson and Dr. Arnold for their assistance.

FOURTH DISTRICT—Dr. Luther W. Holloway *Jacksonville*
Nassau, Clay, Duval, St. Johns.
No report.

FIFTH DISTRICT—Dr. H. C. Dozier . . . *Ocala*
Citrus, Marion.

There are twenty-one physicians in Marion County. Of these twenty-one doctors, nineteen are members in good standing of the county society, one holds an honorary membership and the other, formerly a member, recently refused to pay his dues owing to a new ruling of the society which requires each physician to attend at least two meetings each year in order to retain membership. The secretary has been instructed to explain this ruling to the former member and we believe he will pay his dues when this has been done.

The Marion County Medical Society made a recent effort to revive the Central Florida Medical Society by sending out a questionnaire to all physicians in Marion,

Alachua, Citrus, Levy, Sumter and Lake counties. We received replies to about 60% of the questionnaires, most of which were favorable. It was decided to try again a little later, when we hope to create more enthusiasm.

Four physicians of Citrus County have affiliated with the Pasco-Hernando County Medical Society, and in recognition of this fact the society, at a recent meeting, voted to change its name to the Pasco-Hernando-Citrus County Medical Society. There is only one physician in Citrus County who is eligible, but not a member of this society.

SIXTH DISTRICT—Dr. C. A. Williams, *St. Petersburg*
Pinellas.

My report as councillor for this district may be stated briefly, as follows:

We have a membership in the Pinellas County Medical Society of eighty-five, with paid-up members of over sixty at this writing. The interest continues in our meetings, which are held at the Art School, this city; the Fort Harrison Hotel, Clearwater, and other places that seem best to all concerned. The St. Petersburg physicians are pleased to see such a gain in the interest the up-county men are showing in the Society's growth and development. Our meetings are held semi-monthly, and if we have visiting physicians in our cities who are willing to address us, we have been in the habit of inviting them, especially men who are nationally known. Case histories, one to two papers, are generally offered. Occasionally we serve a lunch or dinner after the meetings, not the rule, however. Every member tries his best to invite all eligible physicians to become members soon as they are located. There is a splendid fraternal spirit and the society is flourishing.

SEVENTH DISTRICT—Dr. M. E. Heck . . . *DeLand*
Brevard, Volusia, Seminole.

As previously reported, I assisted in the organization of the Seminole County Medical Society in November, 1926, at which time the members of the Orange County Medical Society residing in Seminole County withdrew from the Orange County Medical Society and formed a separate organization of their own with the following officers:

President—Dr. Sam. Puleston, Sanford.
Vice Pres.—Dr. J. W. Martin, Oveido.
Secy.-Treas.—Dr. Charles Park, Sanford.

I called up Secretary Dr. Park and also communicated with him by letter, but so far have failed to receive his report of paid-up members for 1927, so, naturally, I cannot furnish you that data.

On October 10th I was in Titusville, Florida, and called on Dr. R. D. Ferguson, Secretary of the Brevard County Medical Society, and at this time he informed me that he expected to call a meeting of his Society within the next two or three weeks and he would notify me so that I could be present at that time, but I do not think they have been able to arrange a meeting since the time of my visit. A few days before the meeting of the Council in Jacksonville, I communicated with him by letter and also by telephone, requesting a report for their district, but so far I have failed to receive same.

While the reports for Brevard and Seminole counties are rather discouraging, I am happy to state that Volusia County is in excellent shape and meetings are being held regularly every month. As Dr. Miller was re-elected Secretary, I have no doubt he has sent you a list of the new officers as well as the list of paid-up members for 1927. If he has not done so, and it is necessary for same to be included in my report, please let me know and I will forward the desired information.

I am glad to report some progress in my district since my appointment as Councillor two years ago, for since then separate Societies have been organized in both Brevard and Seminole counties, and my own Society of Volusia County has maintained her usual standard of excellence. It is my opinion these smaller societies could be stimulated to greater effort if it could be arranged for them to be visited several times a year by one or more men in the profession who might present a paper or illustrated talk or lecture on some pertinent medical topic. This would tend to keep up interest in the local Society and at the same time furnish an opportunity for some ambitious essayist to meet the physicians in the various communities.

In closing, I desire to compliment Dr. Smith on his successful administration and to express my appreciation of the efficient manner in which he has conducted the affairs of the Society.

EIGHTH DISTRICT—Dr. G. C. Tillman, *Gainesville*
Putnam, Levy, Baker, Bradford, Union, Flagler, Alachua.

No report.

NINTH DISTRICT—Dr. W. J. Blackshear, *Panama City*
Holmes, Washington, Bay.

No report.

TENTH DISTRICT—Dr. Herman Watson . *Lakeland*
Polk.

No report.

ELEVENTH DISTRICT—Dr. J. G. DuPuis, *Lemon City*
Dade.

On January 1, 1926, there were sixty qualified members, and on January 1, 1927, there were 154 qualified members in the Dade County Medical Society. Seventeen members were dropped and disqualified for nonpayment of dues.

Removal of Doctors

Dr. A. G. Fort, 301 Medical Arts Building, Atlanta, Ga.
Dr. A. D. Ownby, Greenville, N. C.
Dr. A. D. Fossey, Lakeland, Fla., but not transferred.
Dr. W. H. McHaffey.
Dr. W. D. McDonald, Mont Clear, New Jersey.
Dr. E. Campbell, Logan, Ohio.
Dr. C. Wall, Thomasville, Ga.
Dr. F. P. McCarthy, Boston, Mass.

Irregular Doctors

There are a few doctors still in Dade County who do not belong to our Society, but active steps are being taken to ascertain their qualifications that they might become enlisted as active members in our Society. It has been called to my attention that Naturropaths, Naphropaths and Magic Healers are still at large and practicing upon the public; also that Osteopaths under the present laws are allowed to prescribe narcotic medicines. To properly handle or classify the place in which these particular people are operating business, there seems to be a necessity for more active interpretation by the regular medical profession of the dangers in tampering with disease and health in the human family by the untrained. It has also been called to my attention by the Secretary of the Dade County Medical Society that the New York City Medical Association refuses to give one Dr. M. D. Strong, of New York City, a transfer membership card on the grounds that New York and Florida have no arrangements for reciprocity. Should such be the case, it is recommended that our association have this matter taken up immediately for correction.

Probation Clause

The probation requirements of six months for a physician applying to become a member of the Dade County Medical Society and after his qualification papers are accepted, that he reside in this county six months before

he becomes an active member was rescinded at our regular meeting of November, 1926.

Discussion on So-Called Florida Sores

During our June meeting of the Dade County Medical Society, Dr. J. G. DuPuis appealed to the profession in general that there was prevailing among the laity and a few doctors the idea that there was a disease known as Florida Sores, infecting the inhabitants and particularly the newcomers who move into the State of Florida, and asked the hearty and active co-operation of all the local members of the Dade County Medical Society to eradicate this false impression, and it is reported in this meeting of Councillors of the State Medical Association with the hopes that our Journal will bring this matter before all the members of the state through its columns, requesting that this false propaganda and erroneous stigma against the fair name of the State of Florida be silenced forever.

Visit to the Tri-County Medical Society Reorganization

On July 22, 1926, the Councilor for the eleventh district, in company with Dr. H. C. Babcock, Sr., visited the Tri-County Medical Society reorganization, which was held at Fort Pierce, Fla., and with Dr. H. Mason Smith on the program, assisted in arousing a more active and appreciative position of organized meetings in the regular profession. This meeting was largely attended by the physicians of the three adjoining counties. Those who attended enjoyed a most inviting feast fostered by the Palm Beach Medical Society. This meeting, which was well attended and enjoyed, served as an inspiration to all those who were fortunate to be present. The Councilor received a suggestion from Dr. H. Mason Smith that a visit to Key West with the Monroe County Medical Society would be appreciated, and upon receipt of this suggestion members of the Monroe County Society were addressed by letter asking them as to the advisability, or any suggestions that they might offer, for revival of the regular medical profession in their midst, and there has been no response to my letters of inquiry.

Incorporation of the Dade County Medical Society

The members of the Dade County Medical Society are taking active steps towards the incorporation of that organization.

Beginning the Year Nineteen Hundred Twenty-Seven

The new year, 1927, opened with the annual banquet, with eighty-four members attending. Dr. Fred H. Albee, of New York City, read a paper and illustrated the same with moving picture exhibits on bone surgery, particularly on the hip joint and fracture operations. Also Dr. Joseph M. Burke, Chief Surgeon for the Seaboard Airline Railway Co., was on the program and read a paper on traumatic hernia, challenging the subject, "Does there exist such a thing as traumatic hernia?" The membership dues were reduced from $25.00 to $15.00. The Dade County Medical Society has begun its new year with good fellowship existing throughout its membership, and this year's work promises a year of progressive activity.

TWELFTH DISTRICT—Dr. Baker Whisnant, *Fort Myers*

Glades, Charlotte, Hendry, Lee, Collier.

No report.

THIRTEENTH DISTRICT—Dr. R. C. Hubbard, *Tampa*

Hillsborough, Hernando, Pasco.

As councilor for the thirteenth district of the Florida Medical Association, I am reporting to you just what has been done in this district since May 1st, 1926.

We have gained twenty-six (26) new doctors as members of the Hillsborough County Medical Society, with several more applications for membership with the Board of Censors. There has been quite a desire manifested by all physicians in this county to become members of our society and thereby help out organized medicine.

The counties of Pasco and Hernando have a joint society and have regular monthly medical meetings that are well attended. Good papers are read at each meeting.

As nearly all eligible practicing physicians are already members of this society, there have been no new members added, to the best of my knowledge.

FOURTEENTH DISTRICT—Dr. N. A. Baltzell *Marianna*

Calhoun, Jackson, Gulf.

The interest in organized medicine for the fiscal year of 1926, while greater than that of years previous, has not attained that point which your councilor has striven for or desired; far from that ideal has it approached; but after a recent visit through his district there was found a healthier tone and interest than had been manifested in years previous; and I predict a still greater display of such interest for the year of 1927.

The fourteenth district, a rather large and unwieldy one, the dimension of which is fifty-five miles east and west and one hundred and five miles north and south, has in its confines twenty-two practicing physicians, two having moved out of district in past year; sixteen of whom are in Jackson County, four in Calhoun, and two in Gulf, with an approximate population of 37,000 people.

At our annual election of officers of the Jackson County Medical Society there was a change of personnel and a renewed interest and marked enthusiasm for the coming year. Our purpose is to bring into our society not only the entire number of doctors in our county, there now being only two who are non-members, but those also who are in the other counties of our district.

In short, it appears a most propitious year for organized medicine in the fourteenth district, and your councillor shall spare neither time nor effort to make it the banner year so far as we are concerned.

FIFTEENTH DISTRICT—Dr. John E. Hall *West Palm Beach*

Palm Beach, Broward.

At the time of my appointment as Councillor, there were forty-nine practicing physicians within Palm Beach County, forty-five of whom were paid up and in good standing with the County Society. Since that time six new members have been added, and the applications of four more are pending. There are three physicians within the county who show no disposition to become affiliated with the Society. The Society is an active one, and the individual members take pride in its welfare.

The Broward County Medical Society is a new Society, having been organized in March, 1926.

Since no new members had been added to the list since its organization, orders were issued the Councillor, in July, to investigate the cause of the lack of interest shown by the majority of the physicians of the county in becoming associated with it.

All physicians not belonging to the Society were interviewed, and it was stated by them that the Society had not complied with the requirements of the State Association, in its organization, in that they had not been notified the organization of a County Society was contemplated. The Constitution and By-Laws state: "Before a charter is issued to any County Society, full and ample notice and opportunity shall be given to every such physician in the county to become a member."

Resentment was felt that this requirement had not been met, and they had not been given the opportunity of becoming charter members of the society. At the time of organization, there were thirty-six practicing physi-

cians within the county, but only twelve had been invited to take part in the organization.

The Secretary, Dr. Leigh F. Robinson, aided in bringing about an amicable adjustment, and in getting those physicians not associated with the society to agree to make applications for membership.

These applications were to have been given consideration by the society at the October meeting, but before this meeting took place, another occurrence happened which had a tendency to bring about a more cordial feeling between the physicians of the county.

This was the hurricane. During the reconstructive period following the storm, they were brought into close working contact with each other. A more fraternal spirit was engendered as a result of this association, and personal differences were forgotten. At the present time, the membership has increased from twelve to twenty-four, and the applications of five more are pending.

The personnel of the Broward County Medical Society is not surpassed by that of any other county within the State, and the Councillor predicts a glowing future for it.

In passing, it may be stated that orders were issued from the office of the President of the Florida State Medical Association, in June, 1926, to the Councillor of the 15th District, to attempt stimulation of interest among the members of the defunct Tri-County Society, in the reorganization of a Four-County Medical Society.

This Tri-County Society was formerly composed of the counties of Indian River, Okeechobee and St. Lucie, and the proposed reorganization was to embrace them and, in addition, the newly formed county of Martin.

In compliance with these orders, numerous visits were made by physicians residing within these four counties, and, practically without exception, the desire was expressed that the proposed reorganization be carried out. Assurances were given that the society would receive enthusiastic support toward making it one of the most active within the State organization.

This society was reorganized and a full quota of officers elected at Fort Pierce in July, 1926. Dr. R. C. Boothe, the newly appointed Councillor for the 21st District, which is composed of these counties, can furnish further details as to its present status.

Before closing this report, the Councillor desires to state that, in his opinion, there is a matter which the Council of the Florida Medical Association should take up with the House of Delegates and make definite recommendations toward its adjustment.

This matter is the tendency of certain societies within the State Association toward delaying action upon the applications of new physicians who apply for membership within these societies. It is a matter of common knowledge that certain societies have, or have had, within the past year, rulings which required one should reside within the county for six months before one was permitted to present an application for membership. Then another six months was allowed to elapse before action was taken upon the application.

This is not for the best interests of organized medicine and it should not be permitted to exist. The reason for this is, that it is thought if a physician can be kept out of the local society it will have a tendency to keep him from locating within the county where such a ruling exists.

In certain communities having only one hospital, the ruling is that one is not permitted hospital privileges until admitted to membership in the local society. Naturally, if a new physician seeking a location ascertains that he will not be given hospital privileges for a year, he cannot afford to locate within the community enforcing this requirement.

Selfish motives are responsible for this deplorable condition, and the welfare of the State organization demands that it be rectified.

It is thought that the By-Laws of the Florida Medical Association should require the Credential Committees of the component societies to act upon all applications for membership within sixty days after presentation of such applications. This length of time is adequate for full determination of an applicant's fitness and qualifications, and further delay is altogether inexcusable.

SIXTEENTH DISTRICT—Dr. M. M. Hannum, *Eustis*
Sumter, Lake.

At the beginning of last year the Lake County Society had only six members and met about once a year for election of officers. With the assistance of our secretary we gradually increased our membership to nineteen members and have met regularly, at a luncheon, once a month. Every eligible doctor in the county except one is a member and we hope to have him before long.

The doctors of the society are now planning for a hospital. We hope to call an election for a bond issue of not less than $250,000 within the coming year, and we feel quite sure it will carry, so we feel quite proud of the progress which we have made during the last year. I called a joint meeting of the Lake and Sumter County societies last December, but on account of bad weather the Sumter County members failed to come.

There are only six members of the Sumter County society, but I hope to be able to increase that number at least 100% during the coming year.

The membership of this district has more than doubled during the year, and we hope to continue until every eligible doctor is a member.

SEVENTEENTH DISTRICT—Dr. John S. McEwan *Orlando*
Osceola, Orange.

The Seventeenth District, comprising the counties of Osceola and Orange, has only one Medical Society, the Orange County Medical Society, and this society, up to November, 1926, has been composed of the physicians from Osceola, Seminole and Orange. At that time Dr. Beck, Councillor for the Seventh District, comprising Brevard, Volusia and Seminole, at the request of the profession in Seminole, organized the Seminole County Medical Society, which took ten members from the Orange County Medical Society, leaving us a membership of fifty-five.

At the present time every ethical physician in Orange and Osceola counties belong to the Orange County Medical Society, or their application is pending. Therefore, I have only one Medical Society to meet with and this I do every month, and I doubt if any other Councillor can say the same; that is to say, visit all of his societies every month.

The morale and ethics of the Orange County Medical Society is of the highest and the society always stands ready to back up the association in any work it may suggest.

EIGHTEENTH DISTRICT—Dr. S. G. Hollingsworth *Bradenton*
Manatee, Sarasota.

We have forty-eight physicians, of whom thirty-seven are members of the association. Of the eleven who are not members, probably five or six, are eligible.

Sarasota county holds a meeting once a month at the homes of the several doctors. I think this is a bad plan. The meeting should be held at a regular meeting place.

Manatee County Society meets twice each month, beginning with seven o'clock dinner at The Dixie Grande Hotel. During the year the Sarasota County Society was entertained by Manatee County Society.

NINETEENTH DISTRICT—Dr. D. L. McSwain
Arcadia

DeSoto, Hardee, Highlands.

No report.

TWENTIETH DISTRICT—Dr. Wm. R. Warren
Key West

Monroe.

No report.

TWENTY-FIRST DISTRICT—Dr. Robt. C. Boothe
Fort Pierce

St. Lucie, Okeechobee, Indian River, Martin.

This society was reorganized in July and has met the third Thursday in each month since, except December. We have twenty-one members. The attendance has not been what we hoped for, but as Fort Pierce has been selected as the regular meeting place, we feel there will be a marked increase in the percentage of attendance.

Wish to state we have determined to make the year 1927 one of the best ever and try to reach the 100% mark, both in attendance and dues paid. We are grateful to our President, Secretary and Dr. John E. Hall for the interest they manifested in helping to reorganize this society, and we will do our best to keep it functioning.

NEWS ITEMS

Dr. Joseph Halton, president of the Florida State Medical Golfers' Association, will have plenty of material to put over the tournament at West Palm Beach, as outlined in the June, 1926, Journal of the Florida Medical Association.

* * *

Attending the conference of the Florida Medical Association, the State Board of Medical Examiners and the State Board of Health, held in Jacksonville, February 8th, at the George Washington Hotel, were: Dr. H. Mason Smith, Tampa, President Florida Medical Association; Dr. Shaler Richardson, Jacksonville, secretary-treasurer-editor; Dr. Stewart G. Thompson, Jacksonville, business manager; Dr. Wm. C. Woodward, Chicago, representative of the Bureau of Medical Legislation, American Medical Association; Mr. A. T. Stewart, Tampa, attorney for the Board of Medical Examiners; Mr. Edgar W. Waybright, Jacksonville, senator, and the following members of the three organizations: Drs. S. E. Driskell, Ralph Greene, L. W. Holloway, Wm. McL. Shaw, N. A. Upchurch, and F. Waas, Jacksonville; C. D. Christ and J. S. McEwan, Orlando; Joseph Halton, Sarasota; J. G. DuPuis, Lemon City; R. C. Boothe, Ft. Pierce; Burnie Griffin and J. N. Fogarty, St. Augustine; Eugene G. Peek and H. C. Dozier, Ocala; J. M. Mann, Lake Butler; W. M. Rowlette, Tampa; S. G. Hollingsworth, Bradenton; J. Maxey Dell, Gainesville; W. C. Payne, Pensacola; N. A. Baltzell, Marianna; Herman Watson, Lakeland; J. H. Dyer and L. M. Anderson, Lake City; W. J. Buck and George M. Dawson, West Palm Beach.

* * *

THE COLUMBIA COUNTY MEDICAL SOCIETY HAS THE DISTINCTION OF BEING THE FIRST COMPONENT SOCIETY TO REACH THE 100% PAID CLASSIFICATION FOR THE YEAR 1927. IT IS EVIDENT THAT AN UNUSUAL INTEREST IN THEIR SOCIETY AND IN THE STATE ASSOCIATION IS BEING TAKEN BY THE DOCTORS OF COLUMBIA COUNTY.

* * *

Dr. H. C. Von Dahm, recently in charge of the United States Veterans' Bureau Diagnostic Center, Washington, D. C., has arrived in Lake City and assumed his duties as medical officer in charge of the big government hospital there.

* * *

The following papers were read before the Pinellas County Medical Society during the month of February:

"The Acute Abdomen," Dr. Rufus Hall, Cincinnati (by invitation).

"Diet in Nephritis," Dr. R. H. Knowlton, St. Petersburg.

"Significance of Pain in Lower Back," Dr. T. B. Echard, St. Petersburg.

"Lesions of the Fundus," Dr. H. D. Solomon, St. Petersburg.

"The Treatment of Gonorrhea," Dr. S. B. Bieker, St. Petersburg.

* * *

At the December meeting of the Manatee County Medical Society, Dr. John R. Boling, Bradenton, was elected president of the society, Dr. C. F. Fleming, Bradenton, vice-president, and Dr. J. M. Davis, Bradenton, secretary-treasurer. Dr. Hiram Byrd was elected delegate to the state convention with Dr. T. M. McDuffie alternate.

* * *

ORANGE COUNTY MEDICAL SOCIETY ON THE HONOR ROLL. A CHECK WAS RECENTLY RECEIVED FROM THE SECRETARY OF THE ORANGE COUNTY MEDICAL SOCIETY COVERING 1927

DUES FOR THE ENTIRE MEMBERSHIP OF FIFTY-FOUR PHYSICIANS. THIS SOCIETY MAY WELL BE PROUD OF ITS ACHIEVEMENT.

* * *

Ground was recently broken for the Alachua County Hospital which is to be located in Gainesville. This hospital will cost $150,000 and will be the medical center of this section.

ANDREW FLETCHER QUILLIAN

Dr. Andrew Fletcher Quillian, Bradenton, died at a hospital in Atlanta, January 4, 1927. He was born in 1886 and graduated from the Atlanta School of Medicine in 1910. He practiced his profession in Atlanta until about two years ago when he removed to Bradenton. Dr. Quillian enlisted in the medical corps at the beginning of the World War and served overseas as captain for more than a year. He is survived by his widow, two daughters, his father and one sister.

DUES FOR THE FIVE MEMBERS OF THE NEWLY ORGANIZED MADISON COUNTY MEDICAL SOCIETY HAVE BEEN RECEIVED. A MIGHTY FINE BEGINNING FOR ANY SOCIETY TO MAKE.

* * *

At the meeting of the Atlantic Coast Line Railway held in St. Petersburg, January 20-21st, under the presidency of Dr. G. C. Tillman of Gainesville, Dr. T. H. Bates of Lake City was elected first vice-president for the ensuing year. Dr. Tillman becomes a member of the executive committee.

* * *

At the annual meeting of the Duval County Medical Society for the election of officers held in Jacksonville, December 7th, 1926, Dr. Louie Limbaugh was elected president; Dr. S. E. Driskell, Jacksonville, vice-president; Dr. Kenneth A. Morris, Jacksonville, secretary, and Dr. W. McL. Shaw, Jacksonville, treasurer. Dr. R. B. McIver, Jacksonville, was elected a member of the Board of Governors to serve for three years.

* * *

Physicians from Columbia, Hamilton, Madison and Suwannee counties met at the Colonial Hotel in White Springs, Florida, Friday evening, February 11th, and the meeting was a most enthusiastic one.

Senator McCall delivered the address of welcome for Hamilton County and White Springs in his usual charming manner.

During the social hour and dinner, a delightful musical program was rendered as follows:

Duet—Two violins, Op. No. 1 Q. Pleyel
Dr. O. P. Likins and son, Orion, Jr.

Solo—Voice, Serenade Gounod
Mrs. Likins, Violin Obbl.

Solo—Violin, "Souvenir" Franz Drdea
Orion P. Likins, Jr. (age nine).

Solo—Vocal
(a) "I Know a Hill."
(b) "The Nightingale Has a Lyre of Gold". Whelply
Mrs. Bowden

Solo—Vocal
(a) "On the Adrean Sea" Temple
(b) "Dreams" Strelozki
Mrs. Likins, Violin Obbl.

Duet—Voice and violin,
"Carry Me Back to Ole Virginny."

The fervor with which the physicians joined in the chorus of the last number would indicate that "Ole Virginny" is dear to many medical hearts.

The above program was voted a grand success. The artistic and mature performance of several violin numbers by the small son of Doctor and Mrs. Likins occasioned many remarks of surprise, commendation and prophesies of a wonderfully artistic career. Mrs. Bowden, proprietress of the Colonial Hotel, and Mrs. Likins shared the honors accorded their charming voices, while the genial Doctor Likins, with his old original instrument, was presiding genius over all.

Following the social hour and dinner, the business and scientific session was held.

Doctor Herbert Caldwell, specialist in cardiovascular diseases at the U. S. Veterans' Hospital, Lake City, Fla., read an interesting scientific paper on "The Heart and Its Irregularities," based on a personal observation of several thousand cases. This paper was instructive and greatly enjoyed by all. It was generally discussed by the doctors present.

The gathering voted the doctors of Hamilton County a most gracious host and adjourned to meet in Live Oak in March.

The doctors present were: L. M. Anderson, T. H. Bates, I. A. Black, D. E. Cline, James H. Dyer, W. M. Ives, W. S. Nichols, T. S. Ander-

son, R. A. Barnett, A. L. Blalock, J. H. Corbett, John D. Gable, J. P. Kinsey, G. B. Smithson, L. J. Arnold, Jas. J. Beaty, Herbert Caldwell, Geo. Davis, Robt. B. Harkness, E. Long, S. G. Thompson.

* * *

The monthly meeting of the Lake County Medical Society was held at the Biltavern Hotel, Tavares, February 3rd. The Society had luncheon at noon and held a business meeting after eating.

A report by the committee on temporary hospital arrangements was made by the chairman, Dr. Lodor. The report recommended the acceptance by the Society of the offer previously made by Mr. Waterman of Eustis to make use of two rooms in his hotel, The Fountain Inn, as an emergency hospital during those months when guests were not occupying the hotel. The report and the offer of Mr. Waterman were accepted by the Society after discussion which brought out the fact that there was considerable need for some temporary arrangement of this sort until the new hospital at Tavares could be completed.

The Society voted to raise the amount of dues from $12.00 to $15.00 per year, thus creating a larger fund for emergencies.

A discussion was held regarding a communication received from the State Medical Association concerning the establishment of a home for physicians. The Society moved heartily in favor of the proposition.

Dr. Hannum, chairman of the Hospital Committee, reported to the Society that the preliminary announcement of the presentation of a bill to the next session of the State Legislature providing the necessary legislative machinery for establishing a Lake County hosiptal, had been published and that the bill was being prepared.

The meeting was adjourned after an announcement by the membership committee that one new member had been added to the Society since the first of the year and that application had been received from another.

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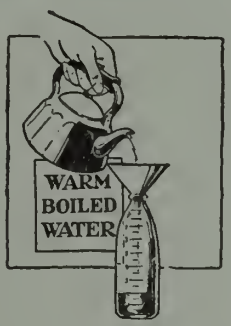
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CONTENTS

	PAGE
President's Address	224
Proceedings of the Fifty-Fourth Annual Meeting of the Florida Medical Association, Inc.:	
General Meeting	228
Scientific Session	228
General Meeting	228
Report of Secretary and Business Manager	228
Report of Mucklow and Ford	232
Report of Executive Committee	234
Report of Committee on Legislation and Public Policy	235
Report of Hospital Committee	237
Scientific Session	239
Meeting of House of Delegates	239
Scientific Session	241
General Meeting	242
Scientific Session	242
Proceedings of the Eighth Annual Meeting of the Florida Railway Surgeons' Association	243
Registration	244
Editorial: (1) Our President. (2) The Fifty-fourth Annual Meeting	247, 248
Presidents and Secretaries of County Medical Societies	249
State News Items	249
Schedule of Meetings, Component Societies of Florida Medical Association, Inc.	xvii

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
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President's Address*

H. Mason Smith, M.D.,
Tampa

The campaign that has been conducted in recent years by the American Medical Association against diploma mills, the practice of quackery, the exploitation of secret remedies, non-scientific cults and state medicine, which is the greatest menace to the profession now existing, together with the campaign for the standardization of medical colleges and the correction of faulty laws regulating the practice of healing arts has so aroused interest that public sentiment is more favorable toward organized medicine and it is now receiving the support of the medical profession more than ever. So the last two years have witnessed the greatest growth in the history of the Florida Medical Association.

Under the conditions now existing with this increased interest and aroused sentiment I feel that I can be of more service to this body by discussing the status of organized medicine than presenting a paper on some scientific subject.

As the curtain is soon to descend on that act of this great drama in which I have taken the roll of your president, I may fittingly speak of the growth of the Association and the activities of the officers during my administration. While most of this information will be conveyed to you through the reports of the various committees and councillors I expect to discuss each phase very briefly and as far as possible give a synopsis of the whole.

SURVEYS AND EXTENSIONS

With a view to stimulating interest, increasing the membership and obtaining uniformity of rules governing admission into membership of component societies, which are the gateways to the State and to American associations, the president has visited the majority of the county societies in the State during the past year. Many counties have been visited with a view toward effecting organizations where no county society existed previously, so that many new counties have come into the State Medical Association. The first activity in this direction was in July, when a meeting was called at Ft. Pierce by Dr. John E. Hall, the councillor of the Fifteenth and adjoining district. Attending this meeting were the majority of the physicians of St. Lucie, Okeechobee, Indian River and Martin counties. A four-county society was organized that night, bringing into the State Medical Association many new members. On the evening of August 24th, through the activities of Dr. D. L. McSwain, councillor for the Nineteenth District and Dr. Herman Watson, councillor for the Tenth District, a meeting was held in Sebring of the physicians of DeSoto, Hardee and Highlands counties. There was already existing in DeSoto County, a component society which was somewhat dormant, but this society combined with Highlands and Hardee, bringing in the two extra counties which were heretofore not organized and creating a tri-county society which has been very much alive. On the evening of December 18th the Columbia County Medical Society, which has been active for many years, had as guests the physicians of Hamilton, Suwannee and Madison counties and this meeting resulted in the organization of the three last named counties. Dr. L. M. Anderson of Lake City, the councillor for the Third District, has since that time visited Taylor and Dixie counties and perfected organizations there.

On September 8th, with a party composed of Dr. J. C. Davis, councillor of the Second District; Dr. N. A. Baltzell of the Tenth, Dr. H. E. Palmer of Tallahassee, Dr. J. Q. Folmar of Chattahoochee, your president visited the First District, being met in the morning at DeFuniak Springs by Dr. J. C. Payne, councillor of the First District, and a party. A complete survey was made of the First District, meetings being held in DeFuniak Springs and Pensacola, which ultimately resulted in a more thorough reorganization of Walton and Okaloosa counties into a component society, and it was decided that the physicians of Santa Rosa would continue their connection with Escambia County Society. In October, with Dr. John E. Hall and Dr. J. G. Dupuis of Dade County, complete surveys were

*Delivered before the Fifty-fourth Annual Meeting of the Florida Medical Association held at West Palm Beach, April 5, 6, 1927.

made of Palm Beach and Broward counties. In December Citrus County united with Pasco and Hernando, forming a three-county society which has in its membership every ethical man in the territory.

THE COUNCILLORS

Just at this time I would like to express great appreciation to the councillors for the work they have done in organizing their districts and bringing into the fellowship of organized medicine many physicians. There are many of these councillors who have visited personally every physician in their district besides attending the various society meetings and have gotten their districts in a state of superb union and organization. There are other councillors who have done practically nothing, who have made no visits to societies, who have not stimulated any interest in their districts and have not even made an annual report. The old idea that a councillor was occupying an honorary position in this body has disappeared and is now remote. The councillor is really the backbone of the organization. We have not heretofore had time in the annual meetings to hear their reports and understand their problems and the work that has been done in their districts, and on this account it has been forgotten that the Association is really being held together by the councillorship. This year, a pre-convention meeting of councillors was held and reports were made by those present, the number of which was fourteen out of the twenty-one councillors; these reports were published in the pre-convention issue of the Journal. On reviewing these reports you can easily understand that most of the councillors have been active. This Association as well as the entire body of organized medicine owes its growth and development to those councillors who have in their unselfish devotion to the cause made personal sacrifices to keep the fires of enthusiasm burning and to keep the organization intact and protect this body of professional men from the menaces and dangers which have not been seen by the masses.

COMMITTEES

The committees have been very active during the year as you will ascertain from the reports which are made by the chairmen. The executive committee in the early part of the year settled an indebtedness of $3,000.00, liquidating a note which has been standing for several years against this body. At the time this was done it was rather doubtful whether we would be able to carry on the expenses of the Journal for the remainder of the year, but it was thought better by the committee to accept an offer of settlement made at that time and borrow the money in the event it was needed later for the publication of the Journal; this, however, was not necessary. This committee has also followed the recommendations of the past president and incorporated the Medical Association, the articles of incorporation appearing in a recent Journal. For this the committee employed a firm of very reliable attorneys and an instrument has been drawn up under which this Association can function and grow, being sufficiently elastic to change with conditions and plastic enough to hold under ordinary circumstances.

By the terms of this charter the directors of the corporation are to be the president, the secretary and treasurer, and the members of the executive committee. Being the directors of this body corporate and the fact that by the charter this Association is allowed to become the owner of property, it is my recommendation that the Constitution of this body be so changed that the executive committee be elective instead of appointed by the president.

The hospital committee has been busy during the season and has done some very constructive work in visiting one hospital in particular and in making recommendations which have been complied with by the board and the staff of this hospital.

The legislative committee has had, during the past year, many problems to work out. The laws in this State have not been such that men practicing under fraudulent licenses could be properly handled. So Dr. Rowlett, the chairman of this committee, succeeded in getting the Federal Authorities interested in diploma mills with the results you know about.

This committee has spent much time in getting up the New Medical Practice Act which if passed will remove the major defects in the law.

One committee which has not functioned and which I apologize to the Association for appointing is the committee on necrology and I shall recommend that the burden of sending obituaries to the Journal shall be placed on the secretary of each component society.

The Scientific Committee has been throughout the year endeavoring to build for this meeting a creditable programme and their work speaks for itself.

To Dr. Stewart Thompson, the business man-

ager, is really due the credit for the efficient conduct of the business side of the Association and a large part of the credit is due him for the growth and increase in membership. He has been used by the president in arranging meetings where a proposed new society was to be created, and has visited the physicians in that district for the purpose of arousing interest. He has acted as secretary to all of the committees and relieved these committees of a great deal of correspondence and bookkeeping which they were unable to do. This has been extraneous to his duties as business manager of the Journal and Association.

To Dr. Shaler Richardson, who is ever jealous of the Journal and the material which goes into it, who is the watch dog of the treasury, who is conservative and safe from a scientific point of view, the Association owes a great debt and in this administration he has acted as a great balance wheel and a guide.

It is my pleasure at this time to report a membership of 1,123 against 980 a year ago and 798 two years ago. The time is fast approaching when the power of organized medicine in this State will be felt even in the legislative halls in Tallahassee. This membership does not mean only so many members, it means that we have that many physicians in the State of Florida who appreciate the value of organization and who are exerting every effort to further this. Following the code which has been adopted by organized medicine it is impossible for organization to become too close or tight, and it is impossible for that thing which is usually referred to as the "medical trust" ever to come out of our organization as long as it follows the code which was adopted by Hypocrites some two thousand years ago.

THE MEDICAL CONFERENCE AND MEDICAL LEGISLATION

On February 8, 1927, there was held in Jacksonville a medical conference which was attended by the State Board of Health, State Board of Medical Examiners and the officers of the State Medical Association. At this time the new Medical Practice Act which you have probably seen in its concrete form was endorsed by these three bodies. This act merely strengthens the old one making it so that diploma mills, and other medical frauds, which have given the Board of Examiners so much trouble, can be handled by State courts. It also does away with reciprocity which is still sanctioned by our law but left to the discretion of the Board of Medical Examiners.

It is now appreciated by most men who have observed medical legislation and seen its application that most medical legislation is futile so long as the back door is open to irregulars and cults who have regularly authorized boards from which they may obtain legal permission to practice. For that reason it has been found that the most effective legislation for the protection of the public against fraudulent practice and quackery, is to provide for a Board of Basic Sciences, from which every applicant desiring to practice any healing science is to be required to obtain a certificate showing a knowledge of the basic sciences, before he can go before his respective board for examination. It was thought by the conference that the time was now premature to endeavor to obtain the passage of a law of this kind and that a bill creating a Board of Basic Sciences should originate with the educators and not with the State Medical Association. But it is to be hoped that the medical profession fosters a sentiment for such a law and that in the near future it will be obtained.

THE WOMAN'S AUXILIARY

Through the efforts of Dr. N. L. Spengler of Tampa, the Woman's Auxiliary was organized at the Gainesville meeting and has already attained considerable potentiality.

Several times during the year I have been asked as to what would be my policy towards the Woman's Auxiliary and what was the particular function of the Auxiliary. Once or twice I have been requested by members to tell the women to "lay off." It seems the Woman's Auxiliary is anxious to accomplish something and nobody knows just what, and the great fear on the part of these physicians has been that it would throw something into the machinery of the State Medical Association which would probably clog it or that it would in some way change the traditional form of entertainment at the conventions.

The Woman's Auxiliary has a great field of constructive work before it, but I trust that it will not make the mistake of trying to do the things that properly belong to the legislative committee.

The greatest service which the Woman's Auxiliary can accomplish is by bringing helpful and wholesome health literature to the attention of other women. It is also possible for them to

constitute themselves into small committees to get on programmes of the women's clubs and civic organizations in their communities, and see that these clubs are not used to promote schemes of medical quackery. A few intelligent members of the Woman's Auxiliary can stop a lot of foolish discussion which is going on in various women's clubs. The main function, however, of the Woman's Auxiliary has to do with the entertainment at the annual sessions of the Medical Association, as in this particular line of work women are especially gracious.

MEDICAL DEFENSE

As you will ascertain from the report of the secretary and treasurer, the financial condition of this body is now satisfactory. This has been brought about by the employment of Dr. Stewart Thompson as business manager and by the raising of the dues for the State Association from $5.00 to $10.00. The past indebtedness has been settled and we now have a balance in the treasury and have given you during the past months a creditable monthly publication. With the increase of membership and the present dues it seems that the State Association can possibly do more for its members in the future. There is, unless some unforseen event occurs, going to be an increase in the treasury of money and it seems to me the time is opportune for the Association to assume some obligation towards its membership in the way of protection against unjust suits for damages in the pursuit of medical practice. Recommendation is made that the incoming executive committee look into this feature and provide as much defense for the members of the State Association as the treasury will justify.

The president does not feel that he has done his entire duty unless he calls to the attention of this body those things which obviously threaten the integrity and the future of the organization both from an economic and scientific viewpoint. If we are to be guided in the future by the past it would be well to read the history of medicine which is full of tragedy. The progress which has been attained in medicine, the achievement of the special discoverers and research workers has come to us through suffering, tears, tragedies and persecutions. In the past the time has been such that no man could express a new idea without a conflict with religious bigotry and disaster to himself. For purely scientific discoveries our forebears have been burned to death for heresy. In speaking of the advancement of medicine in the medieval period, Dr. James Ewing of Philadelphia, in his book on Neoplastic Diseases, remarks in this historical section that in this period, since capable logic could not have been lacking one must suppose that religious and esthetic tendencies in the race unfitted the human mind for mature thought regarding the structures and functions of the human body. Even in modern times research in medicine and other scientific lines has been handicapped by religious bigots and fanatics under the guise of antivivisectionists.

In reviewing the laws that have passed in many states it is time to wonder whether or not scientific research will be further handicapped by the same type of misguided sentiment or ignorance. Many states have already passed laws against the use of text-books in public schools which would show the process of evolution, and have caused to be deleted from such books scientific facts on which could be based a theory of evolution. Are we to sit by and permit such a misguided sentiment to prevent the further advancement of science? Are we in this State going to permit such a law to pass that will negative the science of physiology, comparative anatomy, biology, biochemistry, etc., and prevent the student from obtaining such a grasp of these sciences as will make him a scientific physician able to use and apply modern scientific methods? This assembly should take some action with a view to preventing such a law passing in this State as has made Tennessee the joke of the entire scientific world.

In conclusion, your president feels that he has only scratched the surface of attainment during his administration. There have been so many avenues through which he could exert his efforts, there have been so many opportunities for work that in reviewing the whole he feels very greatly the disappointment in accomplishing so little, but consolation is obtained in an editorial by Bruce Barton on "The Leisure of God" in which he states, "God is leisurely. He has so much time to fuss with sunsets, to plant flowers on deserted prairies where they will never be seen, and for other splendid inefficiencies. A thousand years in His sight are as a day. And it is quite obvious from the arrangements which He has made for perpetuating the race that He has no expectation of all Good Works being finished in our generation."

PROCEEDINGS

of the

FIFTY-FOURTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

HELD AT WEST PALM BEACH, FLORIDA

April 5th and 6th, 1927

The Fifty-fourth Annual Meeting of the Florida Medical Association was called to order at 9 a. m. at the El Verano Hotel, West Palm Beach, Florida, by Dr. W. E. Van Landingham, chairman of the Committee on Local Arrangements. The opening prayer was made by Father F. J. Clarkson. An address of welcome was given by Mr. George R. Bensel, President of the Greater Palm Beach Chamber of Commerce, followed by a response by Dr. H. Mashall Taylor of Jacksonville. Dr. Van Landingham made the announcements of the entertainment features of the meeting. Dr. H. Mason Smith of Tampa, president of the Association, then delivered his address.*

The meeting then adjourned. Immediately following, Dr. W. H. Spiers of Orlando, chairman of the Scientific Program Committee, opened the Scientific Session.

SCIENTIFIC SESSION

At the first meeting of the Scientific Assembly the following papers were read and discussed:

"On the Relation of the Functions of the Glands of Internal Secretion to the Thinking, the Feeling, and the Striving of Man," Lewellys F. Barker, Baltimore, Maryland (by invitation).

"Mechanical Aids in Estimating Cardiac Reserve," Herbert Caldwell, Lake City.

"Treatment of Heart Disease," Meredith Mallory, Orlando.

The second general meeting of the Florida Medical Association was held April 5th, 1927, at the El Verano Hotel, West Palm Beach, at 12:15 p. m. Meeting was called to order by Dr. H. Mason Smith, President. The following reports were read:

*The President's Address will be found on page 224.

REPORT OF SECRETARY, TREASURER, EDITOR OF THE JOURNAL AND BUSINESS MANAGER

To the President and Members of the Florida Medical Association, in Session at West Palm Beach, Florida:

Gentlemen:

MEMBERSHIP

One of the essentials in the strength of any organization is authentic information as to its membership. A statement regarding increase in membership, or the fact that numerous names have been added to a roster does not necessarily indicate additional strength. The enrolling, however, of members who have paid their dues and found a place wherein they are able to serve organized medicine locally or nationally means the growing strength of an organization.

It is with considerable pride that the membership record for the year 1926 is herein reported. A total of 1,110 members were reported by component societies, of which 1,018 paid their annual state dues. Comparison of the figures showing number of dues, by component societies, is interesting. You will find, by comparing the record of paid members, an increase from 645 paid members in 1925 to a total of 1,018 in the succeeding year. This total represents more than at first might be surmised as the annual dues in 1925 were five dollars per member, while in 1926 the dues were doubled.

An authentic membership record by years, previous to 1925, could not be located. Such a record, however, is essential in studying the growth of the Association. By referring to the Journal from 1918 to 1923, inclusive, and taking the total cash paid by members, by years, and dividing by the annual assessment of dues, a record has been compiled, which shows the follow-

ing figures. Full detail of source of information having to do with the basis for the figures used follows:

Dues shown in 1918 report (June, 1918, Journal, page 352), $689.50 @ $3.00=230 members. Back dues collected for 1918 and reported in 1919 report (June, 1919, Journal, page 238), $536.00 @ $3.00 = 179. 230+179=409, total for 1918.

Dues shown in 1919 report (June, 1919, Journal, page 238), $1,031.00 @ $4.50=229 members. Back dues collected for 1919 and reported in 1920 (June, 1920, Journal, page 223), $750.00@$4.50=167. 229+167=396, total for 1919.

Dues shown in 1920 report (June, 1920, Journal, page 223), $1,065.50 @ $3.00=355 members. Back dues collected for 1920 and reported in 1921 (June, 1921, Journal, page 212), $508.00 @ $3.00=169. 355+169=524, total for 1920.

Dues shown in 1921 report (June, 1921, Journal, page 212), $2,246@$5.00=449 members. Back dues collected for 1921 and reported in 1922 (July, 1922, Journal, page 13), $481.00@ $5.00=96. 449+96=545, total for 1921.

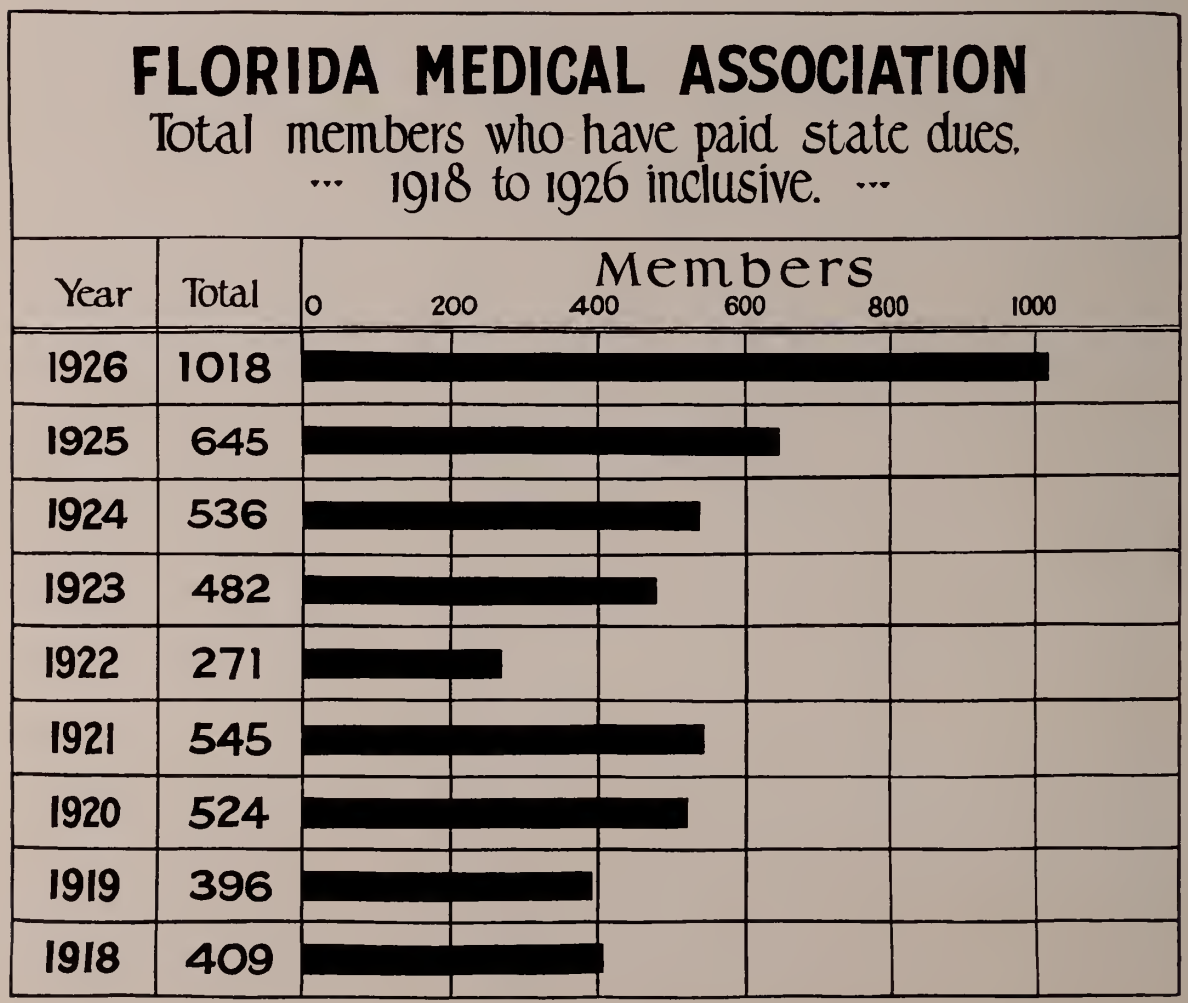
Dues shown in 1922 report (July, 1922, Journal, page 13), $1,080.00@$5.00=216 members. Back dues collected for 1922 and reported in 1923 (June, 1923, Journal, page 194), $275.00@ $5.00=55. 216+55=271, total for 1922.

Dues shown in 1923 report (June, 1923, Journal, page 194), $1,500.00 @ $5.00 = 300 members. Back dues collected for 1923 and reported in 1924 (June, 1924, Journal, page 326), $910.00 @$5.00=182. 300+182=482, total for 1923.

Total number of paid members for 1924, 536, published in June, 1925, Journal, page 215.

Total number of paid members for 1925, 645, published in June, 1925, Journal, page 215.

In order that this information may be visualized, a chart has been prepared showing the total members by years, graphically, in addition to the total figures. The fluctuation in the



growth of membership for the past nine years is pictured on this chart.

The total number of members on the roll at the last annual meeting was 980. Between the date of the meeting and the first of January, this record of membership was increased to 1,110 with 1,018 having paid dues for the calendar year 1926. This record of 1,018 paid members for 1926 is an increase of 38 paid members over the grand total of 980 members reported at the last meeting.

1927 RECORD TO APRIL 5TH

The membership record so far for the year 1927 shows a total of 1,127, of whom 997 have paid this year's dues, the record covering only eleven months as the meeting this year is one month earlier. A complete report cannot be made as activities up to the end of the year will undoubtedly bring in additional members and many doctors who have not yet paid their dues will undoubtedly do so before the end of the year.

This opportunity is taken to publicly recognize the splendid work and activities of the secretaries, treasurers and councillors in preparing and mailing membership rosters and collecting dues. At the present time, sixteen component societies have reported 100% of their entire membership with all annual dues paid up to date. Your officers, who have been watching the growth in membership, deeply appreciate the splendid efforts that have been put forth by the local societies in completing the membership records and collecting annual dues.

For the convenience of members, a membership card has been prepared and put in the hands of every doctor who has paid state dues through his county medical society for 1927. Many instances have arisen when it was necessary for a member to be identified or show evidence that he was a member in good standing. This card shows very briefly, on the reverse side, the objects and benefits of the Association, the form having been approved by the officers of the American Medical Association.

Many requests have been received for typewritten lists of the members of the Association. This would be a very expensive burden on the business office and would not serve the entire membership, if such lists were submitted only on request. For the convenience of the entire membership, a complete roster of all members who paid their dues for 1926 appeared in the February number of the Journal. This official roster, as published, has already filled a very important place in the affairs of the Association and has been commented on favorably from a number of sources. It is planned to have a roster for the entire paid membership appear in the Journal annually.

COUNTY SOCIETIES

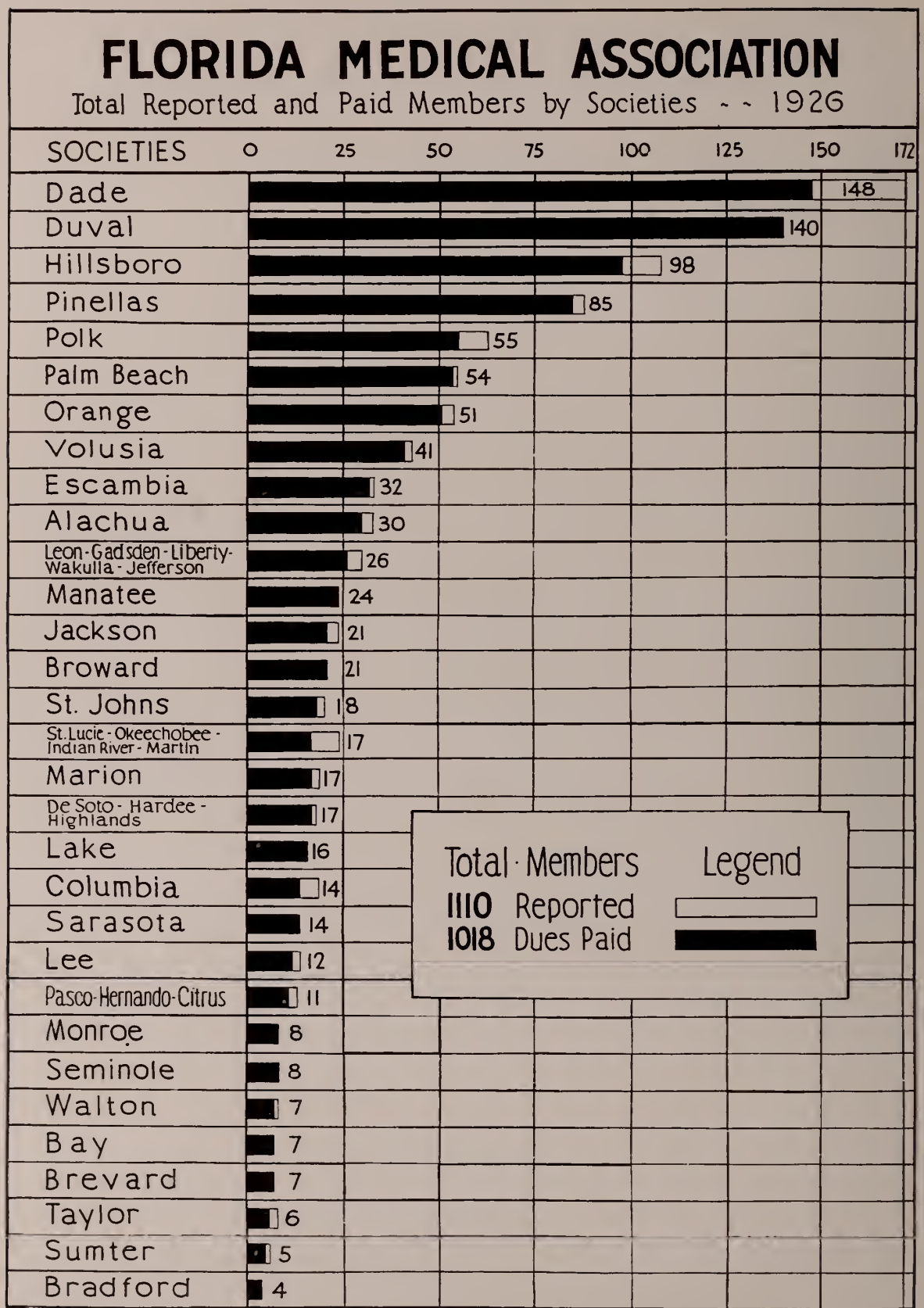
The achievement made in membership is in a large extent due to the activities of the different component or county medical societies. It is amazing to note the enthusiasm displayed in the majority of the county medical societies. Splendid programs have been held regularly, interesting and instructive papers have been read and a general atmosphere of good fellowship indulged in at the numerous meetings held during the past year. On many occasions, your officers have been invited to different county medical society meetings and have attended when possible. The untiring efforts of our President in attending county medical society meetings over the State has been a factor in arousing enthusiasm in many dormant societies.

The boundaries of organized territory have been extended. In the financial report as shown at the last annual meeting and published in the May, 1926, Journal, there were thirty component societies. Three societies have been added since that time: Hamilton, Madison and Suwannee; and Seminole County separated from the Orange County Medical Society for an independent organization, making a total of thirty-four component societies at the present time. In addition to this, Hardee, Highlands and Martin counties were annexed to other societies. For your convenience, a chart has been prepared, showing thirty-one societies for the calendar year 1926 and the total paid members in each society. This chart also shows graphically the number of reported members. Dade County Medical Society heads the list with 172 members, 148 of whom have paid their dues for 1926.

Seven new county societies were organized, reorganized or enlarged during the year and charters issued. These societies are as follows: Broward, DeSoto-Hardee-Highlands, Hamilton, Madison, Pasco-Hernando-Citrus, Seminole and Suwannee.

FINANCES

In my last annual report, I apprised the Association of an indebtedness to the Record Company of $3,170.47. This debt had begun in


FLORIDA MEDICAL ASSOCIATION
Total Reported and Paid Members by Societies - - 1926
SOCIETIES
0
25
50
75
100
125
150
172
Dade 148
Duval 140
Hillsboro 98
Pinellas 85
Polk 55
Palm Beach 54
Orange 51
Volusia 41
Escambia 32
Alachua 30
Leon-Gadsden-Liberty-Wakulla-Jefferson 26
Manatee 24
Jackson 21
Broward 21
St. Johns 18
St. Lucie-Okeechobee-Indian River-Martin 17
Marion 17
De Soto-Hardee-Highlands 17
Lake 16
Columbia 14
Sarasota 14
Lee 12
Pasco-Hernando-Citrus 11
Monroe 8
Seminole 8
Walton 7
Bay 7
Brevard 7
Taylor 6
Sumter 5
Bradford 4
Total Members
1110 Reported
1018 Dues Paid
Legend

1916 and had increased yearly until 1926. It is now my pleasure to tell you that funds were sufficient during the past year to wipe out this debt. After conference with Mr. Scott M. Loftin, attorney for the Record Company, they agreed to accept $2,500.00 cash for the obligation. This having been duly approved by your Executive Committee, the note release was obtained. The audited report of our books up to and including March 21, 1927, shows a balance of $8,596.27 in the Florida National Bank of Jacksonville with no outstanding obligations. This is indicative of the financial health of our organization. The following financial statement, together with report of Mucklow and Ford, Certified Public Accountants, is submitted for your approval:

MUCKLOW & FORD
Certified Public Accountants
Members, American Institute of Accountants
420 Peninsular Casualty Building
Jacksonville, Fla.

April 2, 1927.

Dr. SHALER A. RICHARDSON,
Treasurer, Florida State Medical Association, Jacksonville, Florida.

DEAR SIR:—This is to certify that we have examined the attached statements of cash receipts and disbursements for the period beginning April 20, 1926, and ended March 21, 1927. These statements have been prepared by Dr. S. G. Thompson, Business Manager of the Florida State Medical Association and the Florida Medical Journal, and correctly reflect the total amounts received and disbursed as shown by the books.

We also checked the total amount collected from members, and the total amount of unpaid dues, as shown by the statements with the books, and found each to be correct.

Footings of cash receipts and disbursements records have been proven. Cancelled checks have been examined and compared with the disbursement record. Bank statements have been reconciled.

Yours faithfully,
MUCKLOW & FORD & MCCALL.
By George H. Ford.

CONSOLIDATED CASH STATEMENT
April 20, 1926, through March 21, 1927.

Receipts

Cash in Bank, April 20, 1926		$4,394.18
Dues Collected (Exhibit "C")	$11,555.00	
Earnings from Advertising (Exhibit "D")	3,066.89	
Subscriptions and Miscellaneous Sale of Journal	29.55	—14,651.44
Total Cash to be Accounted for		$19,045.62

Disbursements

General Fund, Expenses (Exhibit "A")	$2,140.03	
General Fund, Refund of Dues (1926-27)	440.00	—$2,580.03
Journal Expense (Exhibit "B")	5,329.82	
Notes Payable	2,500.00	
Library	39.50	—10,449.35
Balance in Bank, March 21, 1927		$8,596.27

Exhibit "A."

CASH STATEMENT—GENERAL FUND
April 20, 1926, through March 21, 1927

Receipts

Cash as per last Audit		$6,435.94
Back Dues Collected (Exhibit "C")	$2,725.00	
Current Dues Collected (Exhibit "C")	8,830.00	—11,555.00
Total Cash to be Accounted for		$17,990.94

Disbursements

Salaries	$1,498.90	
Postage	102.45	
Supplies	131.97	
Telephone and Telegraph	68.12	
Convention Expense	77.89	
Traveling Expense	89.45	
Auditing Expense	12.50	
Incorporation Expense	150.00	
Bond of Treasurer	8.75	—$2,140.03
1926 Dues Refunded	290.00	
1927 Dues Refunded	150.00	
Library (Binding of Journals)	39.50	
To Journal Fund ($3.00 per paid member, 1926 and 1927 collections)	3,517.50	— 6,137.03
Cash Balance		$11,853.91

Exhibit "B."

CASH STATEMENT—JOURNAL FUND
April 20, 1926, through March 21, 1927

Receipts

As Per Last Audit (Overdraft)		—$2,041.76
Earnings from Advertising (Exhibit "D")	$3,066.89	
Subscription and Miscellaneous Sale of Journal	29.55	
From General Fund	3,517.50	— 6,613.94
Total Cash to be Accounted for		$4,572.18

Disbursements

Salaries	$1,514.65	
Postage	105.47	
Printing of Journal	3,530.40	
Supplies	82.38	
Telephone and Telegraph	18.04	
Electrotypes	27.63	
Auditing Expense	12.50	
Convention Expense	30.00	
Bond of Treasurer	8.75	— 5,329.82
Notes Payable	2,500.00	— 7,829.82
Balance Overdraft		—3,257.64
Plus Balance General Fund		11,853.91
Net Cash Balance in Bank		$8,596.27

Exhibit "C."

DUES COLLECTED APRIL 20, 1926, THROUGH MARCH 21, 1927

Name of Society.	Total Members.	No. Paid Members	No. in Arrears	1927 Dues Collected	1927 Refunds	1926 Dues Collected	1926 Refunds
Alachua	35	13	22	$ 130.00	$ 10.00	$ 40.00	$ 10.00
Bay	7	6	1	50.00			
Bradford	6	5	1	50.00	10.00	10.00	
Brevard	11	11	0	100.00		35.00	10.00
Broward	24	24	0	240.00	10.00	70.00	10.00
Columbia	13	13	0	130.00	10.00	70.00	10.00
Dade	165	116	49	1,150.00		740.00	10.00
DeSoto-Hardee-Highlands	17	16	1	150.00		40.00	10.00
Duval	141	141	0	1,410.00	10.00	280.00	10.00
Escambia	35	30	5	290.00		180.00	
Hamilton	6	*6	0	60.00			
Hillsboro	117	83	34	820.00		100.00	20.00
Individuals	9	0	9			15.00	
Jackson	21	11	10	110.00	10.00	230.00	30.00
Lake	16	13	3	120.00		20.00	10.00
Lee	15	14	1	140.00	10.00	30.00	10.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	30	12	18	110.00		70.00	10.00
Madison	5	5	0	50.00	10.00		
Manatee	22	21	1	200.00		10.00	10.00
Marion	20	11	9	100.00		25.00	10.00
Monroe	8	4	4	30.00		15.00	
Orange	54	54	0	540.00	10.00	105.00	10.00
Palm Beach	53	41	12	410.00	10.00	160.00	10.00
Pasco-Hernando-Citrus	15	12	3	100.00		30.00	10.00
Pinellas	84	84	0	860.00	20.00		10.00
Polk	59	59	0	580.00		220.00	10.00
St. Johns	18	18	0	180.00	10.00		10.00
St. Lucie-Okeechobee-Indian River-Martin	22	11	11	100.00		110.00	10.00
Sarasota	15	12	3	110.00		10.00	10.00
Seminole	8	8	0	70.00			
Sumter	6	*1	5	10.00			10.00
Suwannee	7	6	1	60.00	10.00		
Taylor	7	6	1	50.00			10.00
Volusia	43	24	19	230.00		100.00	10.00
Walton-Okaloosa	9	9	0	90.00	10.00	10.00	10.00
Totals	1,123	**900	223	$ 8,830.00	$ 150.00	$ 2,725.00	$ 290.00

*Secretary's dues not yet credited.

**Includes credits for 32 secretaries.

2,725.00—1926 Dues Collected.

$11,555.00—Total Dues Collected.

Exhibit "D."

EARNINGS FROM ADVERTISING

April 20, 1926, through March 21, 1927

May, 1926	$ 206.27
June, 1926	234.21
July, 1926	306.11
August, 1926	331.47
September, 1926	206.71
October, 1926	247.41
November, 1926	315.82
December, 1926	289.26
January, 1927	262.90
February, 1927	215.42
March, 1927	451.31
	3,066.89

ASSETS AND LIABILITIES

March 21, 1927

ASSETS

Cash in Bank	$ 8,596.27
General Fund—Accounts Receivable	2,230.00
Journal—Accounts Receivable	437.25
Furniture and Fixtures (less depreciation)	162.31
Stationery Inventory	72.58
Library	39.50
	$11,537.91

LIABILITIES

Capital Account	$11,537.91

ADVERTISING IN JOURNAL

Revenue from advertising in the Journal has increased rapidly. Well over $1,000.00 additional has been received from this source in cash during the past year as compared with the previous year. This represents a total monthly increase in cash receipts from advertising of over $83.00 per month. A total of $3,556.41 was collected from advertisers during the past twelve months. We have not majored on increasing the advertising in the Journal, although constant efforts have been put forth to show a gradual increase from this source of revenue. All advertisements are submitted for approval and unless the advertiser is worthy of a place in the Journal his money is refunded.

One new feautre in the advertisements is the Ambulance Directory which was approved and shown for the first time on page xv of the February, 1927, Journal. The cards appearing in

the Ambulance Directory are sold for $15.00 each per annum—*i. e.*, twelve times for $15.00.

JOURNAL

The mailing date of the Journal is the 20th. The Journal has been mailed during the past year so as to be received by the membership on the 20th. It has been necessary to print 1,300 Journals each month for the last three months. This is evidence of the tremendous increase in its circulation. Those receiving the Journal are the members of the Association, advertisers and subscribers.

The scale price as contracted for a year ago has been in effect during the past year and this opportunity is taken to express appreciation for the splendid cooperation and work done by the Record Company of St. Augustine where the Journal has been printed.

A regular scale of prices has been submitted for reprints and members who have desired reprints of their articles which appeared in the Journal have been securing the same at a very reasonable cost. Previously, reprints were costing $60.00 or more as compared with $24.00 for the same class of work on the new scale. The prices of reprints were published on page 122 of the November, 1926, Journal.

It has been very gratifying to receive so many original articles during the year, and there has not been a serious shortage at any time. The information contained in the many valuable articles has been disseminated through the entire State and has been read with a great deal of interest by our members. With a growing membership, it would appear that the Journal will have to be enlarged in order to take care of the increase in the number of original articles.

BINDING OF JOURNALS

To permanently preserve one Journal for each month in each year and start a library for the Association, a standard binding was approved. There is now in the possession of the Florida Medical Association, Volume V for 1918-1919; Volume IX, 1922-1923; Volume X, 1923-1924; Volume XI, 1924-1925, and Volume XII, 1925-1926. The years and months for which Journals do not appear among the records of the Association are:

1914—all issues
1915—all issues
1916—all issues
1917—all issues
1918—March
1919—August, November
1920—February
1921—March, October
1922—July

The membership was appealed to through the columns of the Journal for missing issues from which a very hearty response was received. However, as stated above, the file of Journals is deplorably incomplete. Assistance in establishing a complete set of Journals for the Association will be greatly appreciated.

Dr. Thompson and I wish to thank the members of the Association for their wholehearted cooperation in carrying on the work of our office, for it has been by this means alone our organization and its Journal have flourished during the past year.

Respectfully submitted,

SHALER RICHARDSON,
Secretary, Treasurer and Editor of the Journal.

STEWART G. THOMPSON,
Business Manager.

* * *

As Secretary, Treasurer and Editor of the Journal, I want to commend Dr. Stewart G. Thompson, our Business Manager, for his untiring efforts and loyal devotion to the building up of the Association. Through his work during the past two years the Association has profited immeasurably as to finances, membership and enthusiasm. The officers of the Association who are in intimate contact with him will know of his accomplishments and faithfulness to duty. It is earnestly recommended that he be continued in his present office.

SHALER RICHARDSON.

A motion was made to accept the report and it was duly seconded and carried.

A rising vote of thanks was tendered Dr. Richardson and Dr. Thompson for their tireless efforts in placing the Association on a sound financial basis.

REPORT OF EXECUTIVE COMMITTEE

To the President and Members of the Florida Medical Association in Session at West Palm Beach, Florida.

Gentlemen:

The Executive Committee begs leave to hand in the following report:

The first meeting of this Committee was held in Jacksonville on May 25, 1926. At this meeting, your Committee adopted a budget covering all activities of the business office, providing for a total expenditure of $8,275.00. Your Committee also appointed Dr. Stewart G. Thompson as part-time business manager for the ensuing year.

In several other meetings and conferences of the Executive Committee during the course of the year the following official acts were performed:

1. The note in favor of the Record Company, which had accumulated during the previous years, was finally settled. The total amount due the Record Company on this note was $3,695.47. It was settled by the payment of $2,500.00 in cash by this Association.

2. The Florida Medical Association was legally incorporated, in accordance with the action of the Association at its last meeting in Gainesville, and a complete record of the incorporation articles was published in the Journal of the Florida Medical Association for January, 1927.

3. The date of the annual meeting was selected by the Executive Committee after consultation with the officers of the Palm Beach County Medical Society.

4. The Executive Committee approved the refunding of State dues to secretaries of county societies as payment to the said secretaries for services rendered.

5. The Executive Committee also authorized the payment of certain bills rendered by the President of the Association to take care of monies spent by him as traveling expenses while engaged in official work for this Association.

6. We have authorized the auditing of the accounts of the treasurer by Mucklow and Ford, certified accountants, in accordance with the provisions of the By-Laws.

In commenting upon this report, we would say that the business manager has kept the expenses of the Association within the budget approved at our original meeting in May, 1926, and this despite the fact that some of the expenses connected with the Journal have been greater than was originally estimated at this meeting.

We wish to express our great appreciation to Dr. Stewart G. Thompson for the interest and efficiency which he has shown as business manager of this Association. There is no question but that the present excellent standing of the Association, both as regarding membership and financial condition, is due in a very great part to the activities of Dr. Thompson.

We feel that the Association has been particularly fortunate in striking off the old debt of over $3,600 which we owed to the Record Company. Over $1,100—nearly one-third of the whole amount—was deducted from this debt. This deduction we owe to the interest taken by our secretary, Doctor Richardson, in the adjustment. It is pertinent to add that this Association is indebted to Mr. Scott Loftin, President of the Record Company, for great courtesy in this matter.

We also wish to call to your attention the fact that it has not been necessary to borrow any money from the bank this year, although we have paid out this additional $2,500 to the Record Company.

It is pertinent to note that our secretary, Dr. Richardson, has served for the last two years without compensation, turning back into the Association's treasury the salary which was voted to him and which was his by right.

In concluding this report, the Executive Committee wishes to make the following recommendations:

1. That Dr. Stewart G. Thompson be continued as business manager for next year.

2. That a working budget for the activities of the year be approved by the next Executive Committee at their first meeting.

3. That the Association pass a resolution whereby the treasurer refunds to the secretaries of the various county societies the individual state dues which each of these secretaries has paid to the State Association, this refund to take place only after each secretary has filed his annual report with the State Secretary.

Respectfully submitted,

GERRY R. HOLDEN, *Chairman;*
C. D. CHRIST,
SHELDON STRINGER.

A motion was made to accept the report, which was duly seconded and carried.

REPORT OF COMMITTEE ON LEGISLATION AND PUBLIC POLICY

It is very gratifying to your committee to be able to report a year of successful activity. In addition to the joint session between this committee, the State Board of Medical Examiners,

members of the State Board of Health and councillors of the State Medical Society, held at the George Washington Hotel, in Jacksonville, February 8th, there have been several other smaller meetings between members of the above organization at various times during the year, which we believe are going to result in much good for organized medicine in Florida.

Through the untiring efforts of our esteemed president, Dr. H. Mason Smith, the meeting in Jacksonville, on February 8th, will go down in history as the greatest and most harmonious "get-together" meeting that the profession of the State has ever known.

In addition to the members of the State organization, who were in attendance, there were several other men of local and national prominence who were granted the privilege of the floor.

At this meeting the following recommendations of the Committee on Legislation and Public Policy were adopted:

1st. An amendment to the Medical Practice Act, which would take away from the Board of Medical Examiners the power to issue license by reciprocity. This power has never been exercised by the present Examining Board. However, the Board being under political control, we cannot vouchsafe for the future.

2nd. An amendment that would increase the powers of the Board and provide for a more severe punishment for those violating the Medical Practice Act.

In addition to these amendments, two new acts were recommended, namely:

1st. An Act to require the annual registration of all physicians, surgeons, osteopaths, chiropractors, naturopaths, mid-wives and all others practicing the healing art in the State of Florida.

2nd. An act to establish a State Board of Examiners in the basic sciences.

The benefits derived from the proposed first act are obvious to all, being not only of great benefit to the Board of Medical Examiners, but also to the State Board of Health and State Medical Association.

The second act will go a long way in remedying conditions and elevating the standard of the various cults. We are obliged to admit that our efforts to legally regulate the practice of medicine and protect the public against incompetence have only been partially successful, such success has been offset by the various states legalizing numerous cults which have flourished on account of the restrictions surrounding the M. D.

The cults are so firmly entrenched by law that to attempt to control them by direct legislation would be an unsurmountable task. Therefore, if the abolition of the cults by direct attack is impossible—a middle ground must be sought. The nearest approach to satisfaction seems to have been fashioned after the Acts of Basic Science passed in Connecticut and Wisconsin. These acts recognize that non-sectarian practice and cult practice are based on such fundamental sciences as anatomy, physiology, chemistry, bacteriology, and pathology, ignoring all dogmas and fixing for all practitioners of the healing art a uniform minimum standard in the above named sciences.

To avoid prejudices and proselyting, the laws provide that the board be comprised of individuals other than those practicing the healing arts. In Florida, we are endeavoring to place the board under the control of the State Board of Education—persons passing the Basic Science Board will be given a certificate which will entitle them to admittance, after complying with the other necessary requirements, to the various examining boards. Without a Basic Science certificate no applicant can go before his examining board.

While this method may not be perfect, we feel that it approaches perfection nearer than any other plan that has been promulgated.

After several years of persistent efforts on the part of the State Board of Medical Examiners, sufficient evidence has been secured whereby the board will be able to eliminate from the practice of medicine in the State some forty, or fifty, physicians, who were practicing under fraudulent credentials. With the head of the bogus diploma and license organization convicted and sentenced to five years in the Federal prison, we are expecting a great improvement from the quarters of the "charlatan."

Your Committee also recommends to the State Board of Medical Examiners, the creation of some plan whereby applicants will receive a more practical test of ability than that of a written examination—with our modern hospital and laboratory facilities, we believe arrangements could be made for practical tests. In Florida, as in many other states, where the applicant is subjected only to a written test, we find that the examiner has only one-half of one per cent as much contact with the applicant as his teachers

had, which gives the Board of Examiners entirely too little opportunity to determine one's knowledge of the science of medicine—at the best he can only get a fleeting impression, which is apt to be erroneous unless he is a rare judge of knowledge. We approve of the board reserving the privilege of selecting the medical school in which it has to share the responsibility of determining an applicant's ability. We feel that equally as much confidence can be placed in a college of high standards, as knowledge collected in a brief examination.

Your committee recommends that as soon as the financial status of the State Association permits, it will adopt a plan for association, or group, liability insurance for the protection of its members. This type of insurance has been adopted by a large number of state Medical associations, which is proving very satisfactory. In addition to the advantage of securing cheaper insurance, it tends to create a more harmonious feeling between the members and has practically eliminated suits for mal-practice. Until that time has arrived when the State Association can carry group insurance, we recommend immediate adoption of the plan in the various county societies. During these times of financial depression it is well that every physician be on his guard.

In conclusion, we urgently recommend greater activity on the part of county societies legislative and public policy committees. We believe that there are conditions arising in every community whereby an active committee could be of the greatest value. From "time immemorial" it has been known that medical men were great conservatives. It is well that they have been, but time has changed and the public demands to know of matters regarding health—and health measures.

We urgently call upon all county societies' legislation and public policy committees to keep in close touch with their respective legislators, and urge their support of such legislation at the coming meeting of the legislature that may be adopted here today.

Respectfully submitted,

W. R. Rowlett, *Chairman;* H. E. Palmer,
Ernest B. Milam, Jos. Halton,
L. M. Anderson, Carl Williams.

Motion made to accept report, which was seconded and carried.

REPORT OF HOSPITAL AND MEDICAL EDUCATION COMMITTEE

To the President and Members of the Florida State Medical Association:

Your Committee on Hospitals and Medical Education begs to submit report of its activities for the past fiscal year. The preliminary statement might be made that this Committee's appointment by your President is authorized by the American Medical Association through its Council on Medical Education and Hospitals. The data contained in this report is data that has been collected in large part by your Committee for the information of the Council and is tabulated by the Council in the Hospital Number of the Journal of the A. M. A. March 11, 1922. This information has been tabulated in this report under 12 different headings, which follow.

Your Committee feels that this data shows commendable progress upon the part of the State with respect to increasing the number and efficiency and scientific service of its hospitals. It may be particularly noted that the State is taking its proper comparative position in nurses' training and education. Time and opportunity has not permitted your committee to visit in person a great number of the hospitals. Your Committee therefore wishes to extend thanks and appreciation for the cooperation of superintendents and other hospital officials and other agencies throughout the State in securing data.

On November 30, last, your President requested that your Committee make a special visit to DeLand for the purpose of investigating a controversy between Dr. Maurice Heck of DeLand and some of the officials of the DeLand Memorial Hospital. Accordingly Dr. Boyd and Dr. Helms of your Committee met there on December 11. Dr. Folmar was not able to be present. Upon preliminary investigation it was found that the controversy was based largely, if not entirely, upon personal matters, that your Committee considered outside of its jurisdiction. Your Committee, through the courtesy of the Hospital's Superintendent and other officials made a survey of the hospital and its appointments and its scientific and administrative activities, and made such recommendations as it believed to be for the best interests of the hospital and the community which it serves, taking due caution to protect the best interests of the local medical profession without entering into personal controversies.

TABLE NO. 1.—*Nurse Training Schools in Hospitals.*

STATE	Nurse Training School Hospitals. Accredited by State	Not Accredited	Total Schools	Total Beds in Hospitals	Number Schools sending data
Florida....	18	6	24	4,059	20

STATE	Undergraduate Student Nurses. 1st Year	2nd Year	3rd Year	Total Students	Graduates 1926	Students in Graduate Courses	State Requirements. Years—High School	Nurse Training Mo.	Hospitals Without Nurse Training Schools. Number	Beds
Florida...	209	135	134	478	93	3	2	36	56	1,837

TABLE NO. 2.—*Size of Hospitals Having Nurse Training Schools.*

STATE	5-19 Beds Schools	5-19 Beds Students	20-39 Beds Schools	20-39 Beds Students	40-99 Beds Schools	40-99 Beds Students	100-499 Beds Schools	100-499 Beds Students	500-1,000 Beds Schools	500-1,000 Beds Students	Over 1,000 Beds Schools	Over 1,000 Beds Students
Florida...	...	...	7	53	7	89	9	310	...	...	1	26

Total Schools	Total Students
24	478

TABLE NO. 3.—*Types of Hospitals Conducting Nurse Training Schools.*

STATE	General No. Tr. Schools	General Total Students	General Graduates Last Yr.	Nervous and Mental No. Tr. Schools	Nervous and Mental Total Students	Nervous and Mental Graduates Last Yr.	Totals No. Tr. Schools	Totals Total Students	Totals Graduates Last Yr.
Florida...	19	452	85	1	26	8	20	478	93

TABLE NO. 4.—*Size of Nurse Training Schools.*

STATE	Number of Nurse Training Schools Having 1-9 Students	10-19 Students	20-29 Students	30-39 Students	40-49 Students	50-74 Students	75-99 Students	100 Students
Florida...	5	5	5	2	1	2	...	...

TABLE NO. 5.—*Nurse Schools, Students and Graduates According to Size of School.*

Nurse Training Schools Having:	Schools Number	Schools Per Cent	Students Number	Students Per Cent	Graduates 1926 Number	Graduates 1926 Per Cent	Average Students	Average Graduates
9 students or less.....	287	13.8	1,811	2.4	519	3.0	6.3	1.8
10 to 19 students.....	529	25.1	7,490	9.8	1,759	10.0	14.1	3.3
20 to 29 students.....	392	18.7	9,371	12.3	2,241	12.8	23.9	5.5
30 to 39 students.....	268	12.8	9,277	12.1	2,049	11.7	34.6	7.6
40 to 49 students.....	155	7.4	6,815	8.9	1,524	8.7	43.9	9.8
50 to 74 students.....	226	11.0	13,701	17.8	3,099	17.7	60.6	13.7
75 to 99 students.....	116	5.5	10,098	13.2	2,111	12.1	87.0	18.2
100 students or over.....	120	5.7	17,964	23.5	4,220	24.0	149.7	35.1
Totals	2,093	100	76,527	100	17,522	100	36.5	8.4

TABLE NO. 6.—*Nurse Training Schools in Unethical and Irregular Hospitals.*
(Florida Not Listed)

TABLE NO. 7.—*Requirements of Nurse Training Schools.*

STATE	Age Limit Schools Requiring: Less Than 18 Years	18 Years	19 Years	Over 19 Years	Preliminary Education Schools Requiring High School 4 Years	High School 3 Years	High School 2 Years	High School 1 Year	Less	No Requirements
Florida...	..	19	1	..	2	..	17	1	..	..

TABLE NO. 8.—*University Nurse Training Schools.*
(None in Florida)

TABLE NO. 9.—*Hospitals Training Men Nurses.*
(None in Florida)

TABLE NO. 10.—*Nurse Training Schools Offering Graduate Courses.*

FLORIDA Hospital	Connection	City	Number Students	Specialties of Study: Medical: General Medicine	Medical: Pediatrics	Medical: Contagious Diseases	Medical: Tuberculosis	Medical: Nervous and Mental	Surgical: General Surgery	Surgical: Obstetrics	Surgical: Orthopedics	Surgical: Operating Room Technic	Surgical: Anesthesia	Others: Laboratory	Others: X-ray	Others: Dietetics	Others: Administration	Others: Miscellaneous
St. Luke's Hospital Asso.		Jacksonville..	2	Yes		Yes			Yes	Yes								
Bayside Hospital, Inc....		Tampa.....	1											Yes				

TABLE No. 11.—*Number of Nurses Registered by State Boards of Nurse Examiners.*

STATE	No. Registered to Jan. 1, 1924	No. Registered in 1924	No. Registered in 1925	No. Registered in 1926	Total No. Registered to Jan. 1, 1927
Florida...	1,218	376	483	1,020	3,097

TABLE No. 12.—*Registered Nurses in Proportion to Population.*

STATE	Estimated Population July 1, 1926	Nurses States	Nurses per 10,000 People
Florida.....	1,317,000	3,097	23.5

The State has not through this Association or through its general educational system seriously considered the establishment of medical education except the education of nurses and the establishment of a school of pharmacology as a department of the State University. We recommend that the question of the establishment of a school for medical education in this State be made a matter of special study by your next Committee on Hospitals and Medical Education.

Cordially,

JOHN S. HELMS, *Chairman:*
J. E. BOYD,
J. Q. FOLMAR.

Motion made to accept report. Seconded and carried.

The following resolutions were submitted by Dr. W. P. Adamson of Tampa with a recommendation for their adoption in order that the Association might go on record as opposing the proposed legislative bill prohibiting the teaching of evolution in the public schools of Florida:

RESOLUTIONS

Whereas, It has been announced by the press that Hon. Leo Stalnaker, one of the representatives in the State Legislature from Hillsborough County, proposes to introduce a bill in the next session of the Legislature to prohibit the teaching of evolution, or to prohibit the use of text-books which show the theory of evolution, in the public schools of Florida; and

Whereas, All text-books treating on scientific subjects, such as botany, biology, physiology, comparative anatomy, organic chemistry, anthropology, geology, etc., present evolutionary changes, and show process of evolution; and

Whereas, These sciences would be negatived were the facts showing the process of evolution deleted from the books, and the theories contained in the text-books on those subjects would not be scientific but dogmatic; and

Whereas, The mastery of the above mentioned sciences is essential for the premedical and the medical student, and without fair and comprehensive knowledge of these sciences the student cannot develop into a physician, able to apply modern scientific remedies; and

Whereas, The scientific student should not be handicapped by legal barriers which tend to restrain or prevent the acquirement of scientific knowledge and promulgate the same, or to make scientific investigations and researches in any line,

Be it resolved, That the Florida Medical Association oppcses such a bill preventing the teaching of the science of evolution in public schools, and maintains the opinion that the passage of such a bill into a law, would handicap the advancement of medicine and other sciences in the State of Florida.

Be it further resolved, That copies of these resolutions be sent to each member of the State Senate and House of Representatives, now in session.

After a discussion by Dr. Mary Freeman of Perrine, opposing, and Drs. W. M. Rowlett of Tampa, C. D. Christ of Orlando and J. S. Helms of Tampa, favoring resolutions, a motion was made and seconded that resolutions be adopted. Motion carried.

Motion to adjourn.

SCIENTIFIC SESSION

At 2 p. m., April 5th, the Scientific Session again convened. The following papers were read and discussed:

"The Rational of Rœntgen Ray Therapy in Dermatology," E. D. French, Miami.

"Deep Rœntgen Therapy," H. B. McEuen, Jacksonville.

"Congenital Hypertrophic Pyloric Stenosis," J. W. Snyder, Miami.

"Chronic Duodenal Ileus," T. Z. Cason and J. A. Beals, Jacksonville.

"Cæsarean Section," R. A. Ely, Tampa.

MEETING OF THE HOUSE OF DELEGATES

BREVARD COUNTY MEDICAL SOCIETY
Dr. R. D. Ferguson

BROWARD COUNTY MEDICAL SOCIETY
Dr. C. J. Wigg

COLUMBIA COUNTY MEDICAL SOCIETY
Dr. L. M. Anderson

DADE COUNTY MEDICAL SOCIETY
Dr. H. C. Babcock
Dr. J. G. DuPuis
Dr. J. A. Simmons
Dr. J. W. Snyder
Dr. G. Raap
Dr. R. J. Holmes
Dr. M. J. Flipse

DUVAL COUNTY MEDICAL SOCIETY
Dr. B. L. Arms
Dr. A. K. Wilson
Dr. B. H. Goodale
(Entitled to 7 delegates; only three present)

Escambia County Medical Society
Dr. H. L. Bryans
Dr. J. M. Hoffman
Hillsborough County Medical Society
Dr. J. S. Helms
Dr. C. R. Marney
Dr. L. F. Carlton
Dr. E. S. Gilmer
Dr. W. P. Adamson
Lake County Medical Society
Dr. M. M. Hannum
Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society
Dr. J. B. Brinson
Manatee County Medical Society
Dr. S. G. Hollingsworth
Marion County Medical Society
Dr. E. G. Peek
Orange County Medical Society
Dr. E. T. Craney
Dr. G. S. Osincup
Dr. W. H. Spiers
Palm Beach County Medical Society
Dr. W. E. Van Landingham
Dr. B. S. Clay
Pinellas County Medical Society
Dr. M. H. Stuart
Dr. Emil Lustig
Dr. L. Lambdin
Dr. A. J. Wood
Polk County Medical Society
Dr. G. C. Freeman
St. Lucie-Okeechobee-Indian River-Martin County Medical Society
Dr. H. C. McDermid
Suwannee County Medical Society
Dr. H. M. Strickland
Volusia County Medical Society
Dr. Maurice Heck
Walton-Okaloosa County Medical Society
Dr. D. H. Simmons

Alachua, Bay, Bradford, DeSoto-Hardee-Highlands, Hamilton, Jackson, Lee, Madison, Monroe, Pasco-Hernando-Citrus, St. Johns, Sarasota, Seminole, Sumter and Taylor County Medical Societies not represented.

Meeting called to order at 5 p. m., April 5th, by Dr. H. Mason Smith, President. Motion made that substitutes be named for the official delegates and that the house be properly constituted. Motion seconded and carried.

The President announced that the next order of business would be a vote on the amendment to Section 1, Article VII, of the Constitution, which had been presented at the annual meeting the year previous, increasing the number of councillors from fourteen to twenty-one, the councillor districts to be divided as they had been listed in the Journal for several months. This amendment had laid on the table for one year in accordance with Article X of the Constitution.

Unanimously carried.

The President read communications bearing on the expenditures of Dr. S. E. Driskell of Jacksonville amounting to $307.14 in the investigation of "diploma mill" operators, and covering such items as telephone calls, telegrams and salary of Mr. Mack, a special investigator. This sum had been paid by the Duval County Medical Society. Motion was made that in view of the fact that the work done by Dr. Driskell was of state-wide interest, the Duval County Medical Society be reimbursed by the Florida Medical Association.

Motion seconded and carried.

Motion made and seconded that Dr. J. S. Helms of Tampa be nominated as delegate for two years to the meeting of the American Medical Association. Dr. Helms unanimously elected. Dr. H. Mason Smith unanimously elected alternate delegate.

The following resolutions were presented by Dr. C. R. Marney of Tampa:

Whereas, It has come to the attention of organized medicine that one of the most important newspapers of the State, the Tampa Morning Tribune, has taken steps to bar all quack medicine advertising, and all other advertising which in their opinion tends to deceive the public, therefore

Be it resolved, That the Florida Medical Association heartily endorse this step forward in the interests of the public, and that we, individually, and collectively, pledge our support to the publisher, Mr. S. E. Thomason, Tampa, Florida; that the Secretary so notify Mr. S. E. Thomason and send him a copy of this resolution; that the Secretary advise the various societies of the State Association of this action that they may aid in securing like action from the publishers of various local papers;

Be it further resolved, That any other newspaper having taken a similar stand, or in the future taking such a stand be commended by the Florida Medical Association.

Resolutions unanimously adopted.

Motion made for the ratification of charters issued to competent societies organized and reorganized during past year: Broward, Hamilton, Seminole, Suwannee, DeSoto-Hardee-Highlands, and Madison County Medical Societies.

Motion seconded and carried.

Letters read by Secretary from the Hillsborough County Medical Society, Tampa Board of Trade and the City of Tampa inviting the Association to meet in Tampa next year. Dr. J. G. DuPuis then announced that the Dade County Medical Society also requested the convention to be held in Miami. Tampa selected for the annual convention, 1928.

Motion made for the ratification of the new Articles of Incorporation of the Florida Medical Association. Seconded and unanimously carried.

Dr. J. G. DuPuis of Miami introduced for discussion the matter of paying the back salary to Dr. Shaler Richardson, the Secretary-Treasurer and Editor of the Journal, which had not

been paid since the employment of Dr. Stewart G. Thompson, Business Manager.

Dr. Shaler Richardson, Jacksonville: "When I took over the Association work as Secretary and Treasurer and Editor of the Journal two years ago, there was no Business Manager. After I had been in office a few months, I realized that if the Association work was to go ahead, it was necessary to employ someone who could systematize the work and attend to the business details of the Association. The thought occurred to me that this Association, if it was going to grow and prosper, should have a Business Manager. The matter was discussed pro and con and I took the matter up personally with Dr. McEwan, then President of the Association, and he was very strong in his encouragement of the idea. At that time the Association had a debt of something over $3,600. I realized the salary of a Business Manager could not be met with such a depleted treasury, and the Secretary be paid the usual $100.00 a month at the same time. I therefore took the matter up with the Executive Committee and suggested that if they would employ a Business Manager I would donate my salary until such time as the Association could be put on a firm financial basis. We came through the first year very well and while we had paid a great many of the expenses, we still owed some money, so I continued to donate my salary to the employment of the Business Manager, and do not care to be reimbursed for any part of the salary which I have turned into the employment of a Business Manager. It has been my pleasure to do this in order to stimulate the growth of the Association and the Association owes me no money."

Motion made to pay for services of Secretary-Treasurer and Editor of the Journal. Motion ruled out of order on the ground that it was a matter which should rightfully be handled by the Executive Committee.

Dr. Maurice Heck, DeLand: "Mr. President, as a matter of information, the Volusia County Medical Society at the last meeting wished me to inquire as to how long the present State dues will be $10.00, whether it would not be a good thing, now that the Association is on a sound basis, to reduce them to $5.00?"

Dr. Shaler Richardson: "At the present time the State Association, for the first time, has a little money in the bank. If we are going on and prosper and be of any influence in this State, it is going to be necessary for this Association to have a firm financial basis. We have never had any money in the treasury we could use for legal protection and until we create a fund we are going to exist under the same status. I certainly hope that the Association is going on with the present dues of $10.00 in order that we will be able to keep our firm financial footing."

Dr. J. S. Helms, Tampa: "I imagine this discussion of dues is out of order, Mr. President, but you haven't called anybody yet, so I would like to say that rather than see the dues reduced, I would prefer to see them raised. The most of us belong to various civic and fraternal organizations, many of which don't give you near the returns that membership in the Florida State Medical Association does. For instance, I am not trying to fight the interests of the Old Colony Club, but they charge $50.00 a year dues, and your return, of course, is practically nil. But the State Medical Association is of such value to each individual member that I would rather see the dues $25.00 than to be lowered from $10.00."

Motion made by Dr. M. J. Flipse of Miami to empower the Executive Committee to create a fund to be used in promoting proper legislation. Motion ruled out of order inasmuch as the Executive Committee was so empowered.

Meeting adjourned.

SCIENTIFIC SESSION

The third Scientific Session was called to order at 9 a. m., April 6th, and the following papers read and discussed:

"Ureteral Stricture as an Etiological Factor in Kidney Disease," Cayetano Panettiere, Miami Beach.

"Urinary Obstruction from Contracture of the Vesical Orifice," E. Clay Shaw, Miami.

"Surgery of the Male Perineum," A. R. Knauf, Tampa.

"Bismuth as an Antisyphilitic Medicament," Milton M. Coplan and Roy J. Holmes, Miami.

"Caudal Block Anesthesia—A Report of 114 Cases," Leigh F. Robinson, Ft. Lauderdale.

"Roentgenological Examination of the Upper Abdomen," F. K. Herpel, West Palm Beach.

"Nephritis," S. A. Folsom, Orlando.

"Dairying and Its Relation to Preventive Medicine," J. G. DuPuis, Miami.

GENERAL MEETING OF THE ASSOCIATION

The General Session of the Florida Medical Association again convened at 12 o'clock noon, Wednesday, April 6th, West Palm Beach, Florida. Meeting was called to order by Dr. H. Mason Smith, President.

Appointment made by President of Dr. F. Clifton Moor of Tallahassee and Dr. J. Q. Folmar of Chattahoochee as fraternal delegates from the Florida Medical Association to the annual session of the Georgia Medical Association.

Telegram from Dr. J. Maxey Dell of Gainesville, Vice-President of the Association and a member of the State Senate read: "Congratulations. Duties prevent my being with you only in spirit." Motion made to send an official reply to Dr. Dell. Motion seconded and carried.

Motion made that the Chair appoint a committee to draw up resolutions on the death of Dr. Joseph Y. Porter, Sr., one of the organizers of the Florida Medical Association. Motion seconded and carried. Dr. R. H. McGinnis of Jacksonville, Dr. J. E. Boyd, Jacksonville, and Dr. C. D. Christ, Tampa, appointed.

ANNUAL ELECTION OF OFFICERS

Dr. F. J. Waas of Jacksonville nominated by Dr. J. S. McEwan, Orlando, for President. Nomination seconded. Dr. John A. Simmons of Miami nominated by Dr. John S. Helms of Tampa for President. Nomination seconded. Polls closed. Vote by ballot with Drs. C. D. Christ, S. G. Hollingsworth and H. D. Van Schaick as tellers. Dr. Waas 79, Dr. Simmons 78, with two votes incorrectly written. Election struck off by President with the order that another ballot be cast. Second ballot: Dr. Simmons 81, Dr. Waas 77. Dr. Simmons declared elected as President of Association.

Dr. John S. Helms and Dr. G. Raap appointed by President to escort Dr. Simmons to Chair.

President: "Friends, I am not much of a speaker, but I feel very, very grateful. I feel so deeply impressed that even though I were a speaker I could not adequately express myself at this time. I feel that this is a great honor, the greatest honor which my brother practitioners from this State can bestow upon me. I have always hoped this might happen to me—not worked for it, especially—but I have always hoped that I might some day have my friends feel I was eligible to be President of the Florida State Medical Association. I will try to carry out the work started by our former President, and, if possible, to equal it. It is not at all likely that I can surpass it, but it will be my effort to strive to surpass his record, if it is possible.

"I believe the next thing in order is the presentation of the outgoing President's button. This will be made by Dr. Helms."

Dr. J. S. Helms, Tampa: "Dr. Smith, on behalf of the Florida State Medical Association, as an expression of the appreciation we have for you as a man, as a professional gentleman, and retiring President of this Association, I take great pleasure in pinning this button on you as an insignia of the past Presidency of this Association."

Dr. Smith: "Thank you."

Rising vote of thanks given to outgoing President.

Dr. W. E. Van Landingham of West Palm Beach nominated by Dr. W. M. Rowlett of Tampa for First Vice-President. Nomination seconded. Voted unanimously that the nominations be closed and the ballot cast for Dr. Van Landingham. Dr. Van Landingham declared elected First Vice-President.

Dr. Fred Bowen of Jacksonville nominated by Dr. W. P. Adamson of Tampa for Second Vice-President. Nomination seconded. Motion made, seconded and voted unanimously that the nominations be closed and the ballot cast for Dr. Bowen.

Dr. John E. Hall of West Palm Beach nominated for Third Vice-President. Nomination seconded. Motion made, seconded and voted unanimously that the nominations be closed and the ballot cast for Dr. Hall.

Dr. Shaler Richardson of Jacksonville nominated by Dr. W. P. Adamson of Tampa for Secretary-Treasurer. Nomination seconded. Motion made, seconded and a rising vote given that the nominations be closed and the ballot cast for Dr. Richardson.

Upon motion, duly seconded, meeting adjourned, *sine die*.

SCIENTIFIC SESSION

The last session of the Scientific Assembly was called to order at 2 p. m., April 6th. The following papers were read and discussed:

"The Tonsil as a Primary Focus of Infection," F. Peter Herman, West Palm Beach.

"Why the General Practitioner Should be Familiar with the Anatomy and Pathology of the Mastoid and Petrous Portions of the Temporal Bone," (with lantern slide demonstration), Jas. B. Parramore, Jacksonville.

"Gunshot Wounds of the Rectum," L. A. Peek, West Palm Beach.

"Normal Diets for Diabetics," Arthur L. Walters, Miami Beach.

"The Significance of Recurrent Vomiting or the So-Called 'Bilious Attacks' in Children," Geo. L. Cook, Tampa.

PROCEEDINGS OF THE EIGHTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION

El Verano Hotel, West Palm Beach, Fla., April 4, 1927.

The eighth annual meeting of the Florida Railway Surgeons' Association was called to order in the Blue Room of the Hotel at 2 p. m. by Dr. Leon Ashley Peek, chairman of the local committee on arrangements.

After the invocation by Rev. Dr. Wm. P. S. Lander, Rector of the Episcopal church, welcome addresses were delivered by Hon. J. C. McReary, Mayor of West Palm Beach, and Dr. Leon Ashley Peek, chairman of the committee on arrangements, on behalf of the Palm Beach County Medical Society.

The response to the addresses of welcome was delivered by Dr. L. M. Anderson, of Lake City.

The president's address was then delivered by the president, Dr. Joseph N. Fogarty, chief surgeon of the F. E. C. Ry. Co., and proved a very interesting talk on the various and manifold duties and obligations of the local surgeons, both to the railroads and the victims of accidents occurring on the various lines of railroads.

The minutes of the preceding meeting were then read and approved.

Nine new members were then elected, consisting of the following local surgeons living in the state: Drs. C. W. Shackleford, West Palm Beach, S. A. L. Ry.; Wm. E. Van Landingham, West Palm Beach, F. E. C. Ry.; V. L. Brown, West Palm Beach, F. E. C. Ry.; M. D. Thomas, Miami Beach, Miami Beach Street Railway Co.; R. H. Mooty, Winter Haven, S. A. L. Ry.; M. M. Hannum, Eustis, A. C. L. Ry.; Geo. M. Floyd, Hawthorne, A. C. L. Ry.; J. C. F. Hutton, Miami Beach, S. A. L. Ry.; F. S. Whiteman, West Palm Beach, S. A. L. Ry.

Program

Address by Hon. Frank P. Fleming, of the local department of the S. A. L. Ry., of Jacksonville.

Address by Hon. John P. Stokes, of the legal department of the F. E. C. Ry. of Miami.

These two addresses were along the line of legal phase of the local surgeon's activities, and were of immense interest and value to the membership of the association. They, together with the address of the president, were orations rather than written papers. All the addresses were of such poignant interest and contained so many items of information that it is to be regretted that they were not in such form as to be published, that the entire membership of the association might have had the benefit of them.

"Osteitis Deformans," an illustrated paper, read by Dr. J. W. Snyder and illustrated with lantern slides by Dr. G. Raap, both of Miami.

The necrology committee, Dr. T. M. Rivers, of Kissimmee, chairman, offered the following resolution:

Whereas it has pleased the Divine Ruler of the Universe to remove from our earthly assemblage the following members, viz:

Dr. B. L. Padgett, Hastings.
Dr. Charles M. Roberts, Umatilla.
Dr. George W. Holmes, Sharps.
Dr. W. L. Hughlett, Cocoa.
Dr. C. R. Darrow, Ft. Lauderdale.
Dr. E. C. Atwood, Daytona.
Dr. Max Springer, Miami.
Dr. C. J. Lewis, Jacksonville.
Dr. E. B. Howell, Chuluota.
Dr. W. H. Howell, Leesburg.

and

Whereas, Each of these members followed exemplary lives in the healing art, going many times to minister to the sick when home and family and business and pleasures were calling them elsewhere, and

Whereas, They gave their best service to the railroads which they served, never faltering to answer any call, whether it were day or night, fair or stormy weather, forgetting self and selfish motives for the duties which they had obligated to assume, and

Whereas, Their demise has been an irreparable loss to the communities which they served, the railroads which they served, to their dear families, and to this association; therefore, be it

Resolved, That this entire assemblage arise and bow in humble submission to Him who does things in such mysterious manner, giving a moment's thought to the self-sacrificing lives of these departed members of our association, and be it further

Resolved, That these names be placed on the honor-roll of this association, being remembered as those who have followed the healing art well and worth remembering, and be it further

Resolved, That a copy of these resolutions be spread upon the minutes of this association, that a copy be sent to each of the families of these departed members, and that a copy be sent to The Journal of the Florida Medical Association for publication therein.

The following committees have been appointed:

SCIENTIFIC PROGRAM COMMITTEE

L. A. Peek, *Chairman* West Palm Beach
H. M. Strickland Live Oak
Geo. R. Creekmore Brooksville

COMMITTEE ON LOCAL ARRANGEMENTS

L. S. Oppenheimer, *Chairman* Tampa
W. P. Adamson Tampa
J. C. Dickinson Tampa
R. R. Duke Tampa
A. R. Beyer Tampa
W. J. Lancaster Tampa

NECROLOGY COMMITTEE

J. F. Wilson, *Chairman* Lakeland
Gordon Stanton Hastings
F. C. Moor Tallahassee

REGISTRATION

The following registered during the Fifty-fourth Annual Meeting of the Florida Medical Association held at West Palm Beach, April 5th and 6th:

OFFICERS

Smith, H. Mason, President Tampa
Waas, F. J., 1st Vice-President Jacksonville
Richardson, Shaler, Sec'y-Treas. . . . Jacksonville
Thompson, Stewart G., Business Mgr. . Jacksonville

MEMBERS

Alachua County Medical Society.

Floyd, G. M. Hawthorne
Summerlin, J. L. Gainesville
Tillman, G. C. Gainesville

Bay County Medical Society.

Nixon, J. M. Panama City

Brevard County Medical Society

Ferguson, R. D. Titusville
Page, W. C. Cocoa

Broward County Medical Society

Bertram, A. J. Hollywood
Hendricks, E. M. Ft. Lauderdale
Klussman, H. A. Ft. Lauderdale
Klussman, R. M. Ft. Lauderdale
Lowry, R. S. Ft. Lauderdale
Maxwell, Leslie H. Ft. Lauderdale
McClellan, G. S. Pompano
McLowry, Elbert Hollywood
Peavy, H. J. Ft. Lauderdale
Repass, R. E. Ft. Lauderdale
Robinson, Leigh F. Ft. Lauderdale
Roper, L. E. Hollywood
Skiff, F. S. Ft. Lauderdale
Stovall, R. H. Ft. Lauderdale
Walker, H. A. Hollywood
Wigg, C. J. Ft. Lauderdale

Columbia County Medical Society

Anderson, L. M. Lake City
Caldwell, Herbert Lake City
Farnell, P. C. Lake City
Nichols, W. S. Lake City

Dade County Medical Society

Adkins, E. H. Miami Beach
Aranovitz, S. Miami
Babcock, Donald T. Miami
Babcock, H. C. Miami
Barge, H. A. Miami
Benton, G. H. Miami
Brannen, Cecil Coral Gobles
Burch, R. N. Miami
Chambers, S. E. Miami
Chandler, G. E. Miami
Claxton, W. A. Miami
Coplan, M. M. Miami
Dunaway, C. E. Miami
Edwards, S. R. Miami Beach
Flipse, M .J. Miami
Foxworthy, F. W. Miami
Freeman, Mary Perrine
French, E. D. Miami
Ghertler, Max Miami
Gowdy, R. A. Miami
Haisfield, H. B. Coconut Grove
Harris, D. W. Miami
Hodsdon, B. F. Miami
Holmes, R. J. Miami
Hutton, J. C. Miami Beach
Jordan, W. B. Homestead
Keeler, F. L. Miami
Kennon, C. L. Miami
Kirsch, M. D. Miami
Lucinian, J. H. Miami
Lyell, R. O. Miami
McKibben, W. M. Miami
Manson, P. J. Little River
Milton, J. D. Miami
Moore, Alfred Kendall
Nabers, L. W. Miami
Newton, S. B. Miami Beach
O'Quinn, L. H. Hialeah
Palmer, B. Miami
Panettiere, C. Miami Beach
Payton, F. J. Miami Beach
Pearson, Homer Miami
Pearson, Nelson Miami
Pearson, R. J. Miami
Preston, R. W. Miami
Raap, G. Miami
Roche, C. F. Miami Beach
Shaw, E. Clay Miami Beach
Simmons, J. A. Miami
Simpson, J. R. Miami
Skaggs, P. T. Miami
Snyder, J. W. Miami
Summers, Albert T. Miami
Thomas, M. D. Miami
Tower, J. B. Homestead
Tumlin, C. E. Miami
Turner, J. C. Miami
Walters, A. L. Miami Beach

Whitaker, J. L. Miami
Wilson, M. C. Miami
Wood, A. W. Miami
Woodard, R. C. Miami
Youmans, I. C. Miami

DeSoto-Hardee-Highlands County Medical Society

Brown, L. V. L. Sebring
Hubert, M. A. Avon Park
Kayton, M. C. Wauchula
Kirkpatrick, C. H. Arcadia
McSwain, D. L. Arcadia
Mitchell, J. W. Sebring
Weems, H. V. Sebring

Duval County Medical Society

Adams, W. H. Jacksonville
Arms, B. L. Jacksonville
Bayless, W. C. Jacksonville
Beals, J. A. Jacksonville
Blinn, T. A. Jacksonville
Boone, J. L. Jacksonville
Bowen, F. J. Jacksonville
Boyd, J. E. Jacksonville
Brink, F. A. Jacksonville
Cason, T. Z. Jacksonville
Copeland, S. M. Jacksonville
Driskell, S. E. Jacksonville
Fisher, L. C. Green Cove Springs
Fort, F. L. Jacksonville
Gammon, J. E. Jacksonville
Goodale, B. H. Jacksonville
Harrell, D. E. Jacksonville
Harris, H. H. Jacksonville
Hensen, G. E. Jacksonville
Jelks, Edward Jacksonville
Johnston, C. W. Jacksonville
Kirby-Smith, J. L. Jacksonville
Knauer, W. J. Jacksonville
Limbaugh, Louie Jacksonville
Manning, W. S. Jacksonville
McEuen, H. B. Jacksonville
McGinnis, R. H. Jacksonville
McIver, R. B. Jacksonville
Morris, K. A. Jacksonville
Norris, S. R. Jacksonville
Parramore, J. B. Jacksonville
Pittman, J. H. Jacksonville
Richards, F. Jacksonville
Richardson, Shaler Jacksonville
Sellers, E. T. Jacksonville
Shaw, W. McL. Jacksonville
Skipper, C. T. Jacksonville
Taylor, H. M. Jacksonville
Thompson, T. C. Jacksonville
Van Schaick, H. D. Jacksonville
Veal, E. W. South Jacksonville
Waas, F. J. Jacksonville
Wilson, A. K. Jacksonville

Escambia County Medical Society

Bryans, H. L. Pensacola
Fraser, Donald S. Pensacola
Hoffman, James Mortimer Pensacola
Lischkoff, M. A. Pensacola
Pierpont, J. H. Pensacola
Turberville, J. S. Century

Hillsboro County Medical Society

Adamson, W. P. Tampa
Allen, Bundy Tampa
Arroyo, C. F. Tampa
Beyer, A. R. Tampa
Bidwell, A. M. Tampa
Blake, W. C. Tampa
Carlton, L. F. Tampa
Cook, Geo. L. Tampa
Duke, R. R. Tampa
Ely, R. A. Tampa
Estes, J. L. Tampa
Farrior, J. B. Tampa
Gilmer, E. S. Tampa
Helms, J. S. Tampa
Holton, W. J. Plant City
Knauf, A. R. Tampa
Lowry, B. W. Tampa
Maechtle, E. W. Tampa
Marney, C. R. Tampa
Oppenheimer, L. S. Tampa
Rowlett, W. M. Tampa
Smith, H. Mason Tampa
Smoak, Edw. Tampa
Taylor, J. W. Tampa

Lake County Medical Society

Hannum, M. M. Eustis

Lee County Medical Society

Anderson, J. M. Sears
Harrison, W. A. Ft. Myers
Martin, Leldon W. Punta Gorda

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

Brinson, J. B., Jr. Monticello
Dozier, L. L. Tallahassee
Folmar, J. Q. Chattahoochee
Moor, F. Clifton Tallahassee
Wilhoit, S. E. Quincy

Manatee County Medical Society

Hollingsworth, S. G. Bradenton

Marion County Medical Society

Freeman, Albert H. Ocala
Moore, J. N. Ocala
Peek, E. G. Ocala
Von Engelken, L. H. Ocala

Orange County Medical Society

Andrews, M. M. Orlando
Beardall, H. M. Orlando
Brinson, H. Kissimmee
Chappell, J. R. Orlando
Christ, C. D. Orlando
Craney, E. T. Orlando
Folsom, S. A. Orlando
Ford, J. A. Orlando
Geiger, H. S. Kissimmee
Gwynn, H. W. Orlando
Ingram, L. C. Orlando
McElroy S. Orlando
McEwan, J. S. Orlando
Mallory, M. Orlando
Marshall, C. J. Sanford

Osincup, G. S. Orlando
Rivers, T. M. Kissimmee
Sinclair, W. E. Orlando
Spires, W. H. Orlando

Palm Beach County Medical Society

Arnold, W. O. West Palm Beach
Baldwin, R. H. West Palm Beach
Bazemore, Mary Knott West Palm Beach
Binkley, John Frey West Palm Beach
Blair, W. M. West Palm Beach
Brantley, G. H. Lake Worth
Brown, V. L. West Palm Beach
Buck, W. J. West Palm Beach
Clay, B. S. West Palm Beach
Cooley, R. O. West Palm Beach
Dawson, Geo. M. West Palm Beach
Denison, R. C. Lake Worth
Gardner, W. H. West Palm Beach
George, W. W. West Palm Beach
Gerlach, H. P. West Palm Beach
Gill, R. S. West Palm Beach
Gunter, T. D. West Palm Beach
Hall, John E. West Palm Beach
Heath, G. W. West Palm Beach
Henry, G. F. West Palm Beach
Herman, F. P. West Palm Beach
Herpel, F. K. West Palm Beach
Jared, Vernon M. West Palm Beach
Lewis, R. G. West Palm Beach
Miller, Alice R. West Palm Beach
Netto, Lloyd J. West Palm Beach
Papot, Grace E. West Palm Beach
Pearson, Colquitt Kelsey City
Peek, L. A. West Palm Beach
Peery, E. W. West Palm Beach
Powell, J. A. West Palm Beach
Roderick, A. F. Palm Beach
Rowe, A. L. Lake Worth
Rozier, L. M. West Palm Beach
Sayad, William Y. West Palm Beach
Shackleford, C. W. West Palm Beach
Shackleford, W. L. West Palm Beach
Schliffli, O. F. West Palm Beach
Smart, B. F. Lake Worth
Sory, B. B., Jr. Lake Worth
Stone, V. D. West Palm Beach
Tatom, F. L. Lake Worth
Van Landingham, W. E. West Palm Beach
Webb, Roy West Palm Beach
Whitman, F. S. West Palm Beach

Pasco-Hernando-Citrus County Medical Society

Creekmore, Geo. R. Brooksville

Pinellas County Medical Society

Lambdin, L. St. Petersburg
Lustig, Emil St. Petersburg
Prather, B. T. St. Petersburg
Raborn, J. D. St. Petersburg
Stuart, M. H. St. Petersburg
Timberlake, Gideon St. Petersburg
Wood, A. J. St. Petersburg

Polk County Medical Society

Carefoot, G. H. Ft. Meade
Cline, R. L. Lakeland
Farmer, C. R. Lakeland
Freeman, G. C. Lakeland
Hargrove, J. L. Bartow
Lester, J. G. Lakeland
Mooty, R. H. Winter Haven
Overstreet, G. C. Lakeland

Sarasota County Medical Society

Kennedy, David R. Sarasota

Seminole County Medical Society

Martin, J. W. Oviedo

Suwannee County Medical Society

Strickland, H. M. Live Oak

St. Johns County Medical Society

Burnett, W. E. St. Augustine
Fogarty, J. M. St. Augustine
Stanton, Gordon Hastings

St. Lucie-Okeechobee-Indian River-Martin County Medical Society

Boothe, R. C. Ft. Pierce
Clark, H. D. Ft. Pierce
Council, M. D. Ft. Pierce
Dame, Leland H. Ft. Pierce
David, C. L. Okeechobee
Dunn, J. C. Ft. Pierce
Grossman, Frederick A. Vero Beach
McDermid, H. C. Okeechobee
Newnham, J. A. Stuart
Parker, J. D. Stuart
Whiddon, L. L. Ft. Pierce

Volusia County Medical Society

Farnell, W. W. New Smyrna
Heck, Maurice DeLand
Pay, W. C. DeLand
Taylor, J. E. DeLand
Warren, E. W. Palatka
Williams, W. J. Seville

Walton-Okaloosa County Medical Society

Simmons, D. H. DeFuniak Springs

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Duffin, Chas. E. Orlando
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Johnson, Lucille Miami
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McKenzie, E. N. Miami
Oughterson, W. A. West Palm Beach
O'Rourke, R. M. Miami
Perse, C. W. Tampa
Richardson, J. C. West Palm Beach
Smith, Erwin Pompano
Spooner, D. S. S. Pahokee
Stoner, C. R. Jacksonville
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Wilson, B. C. Jacksonville
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JOHN A. SIMMONS, OUR PRESIDENT

Dr. John A. Simmons, recently elected President of the Florida Medical Association, is well worthy of the honor accorded him by the medical profession of the state. For years he has labored for the cause of organized medicine to the upbuilding of our Association. For two consecutive years he served as first vice-president of the Association as well as having served as second and third vice-presidents and a member of the Scientific Program Committee.

Dr. Simmons was born in Saline County, Arkansas, August 25, 1877. He received his medical degree from the University of Arkansas where he was president of his class during his junior and senior years. While serving an internship in the Pulaski County Hospital, Little Rock, Arkansas, he met Miss Alma Parker, now Mrs. Simmons, who, preceding their marriage, was superintendent of the infirmary of the Arkansas State Hospital for Nervous Diseases.

For two years after graduation, Dr. Simmons practiced medicine in Arkansas, and in 1907 moved to Arcadia, Florida, where he organized and built the Simmons Sanitorium. During the World War he served on the exemption board and the Simmons Sanitorium was used as an emergency hospital during the construction of two aerial camps situated near Arcadia. Since June, 1923, Dr. Simmons has been practicing in Miami where he specializes in surgery. He is a member of the surgical staff of the Jackson Memorial Hospital.

There are, in the Simmons home, three children—two sons and a daughter—the eldest son attending the University of Florida and the daughter the Florida State College for Women.

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THE FIFTY-FOURTH ANNUAL MEETING

The fifty-fourth annual meeting of the Florida Medical Association broke all records for enthusiasm and attendance. Three hundred and twelve registered during the two-day session, of whom two hundred and eighty-nine were members and twenty-three visitors and guests, all sections of the state being represented. The scientific program was well prepared and executed. The papers were of the highest type and were unusually interesting. The Palm Beach County Medical Society deserves the highest praise for the perfect planning of the Association's visit. As host, the society has set a pace that will require great effort to equal. Attending the banquet were five hundred and twenty-five members and guests. Our hats are off to our host—the Palm Beach County Medical Society.

PRESIDENTS AND SECRETARIES

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Secretary—J. L. Summerlin . . . Gainesville

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Bradford County Medical Society—
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NEWS ITEMS

The regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society, held March 8th, was well attended and has been reported as a most interesting gathering. Dr. H. Mason Smith, president of the Florida Medical Association, attended and gave an interesting and inspiring talk on "Organized Medicine" and a resumé of what the state association had accomplished during the past year and an outline of what it hoped to accomplish during 1927. Dr. R. C. Hubbard, of Tampa, councillor for the Thirteenth District, attended and gave an interesting talk on "The Value of Maintaining Membership in the County and State Medical Societies". A delightful dinner was served at the Hotel Zephyr, which was followed by a scientific program.

At the March 8th meeting of the Escambia County Medical Society, a resumé of the proposed medical practice bill, to be presented at the next Florida Legislature, was submitted and discussed. A scientific program followed the business session.

The Columbia, Hamilton, Madison and Suwannee County Medical Societies met in regular session the evening of March 11th at Stumble Inn, on the Banks of the Suwannee River. Mr.

C. W. Williams, secretary of the Chamber of Commerce of Suwannee County, on behalf of Live Oak and Suwannee County, most cordially welcomed the visitors, and in an interesting talk, told of the recent developments that had been made in an industrial and agricultural way in Suwannee County, and other counties of Northern Florida. Drs. H. F. Airth and W. S. White spoke on the advantages to be gained in the society from a scientific and social standpoint. Dr. P. B. Harkness, of Lake City, spoke on fellowship, closing his remarks with the poem "Abou Ben Adhem", by Leigh Hunt. Dr. L. M. Anderson, Lake City, councillor of the third district, gave a concise report on the meeting of the councillors recently held in Jacksonville. Dr. T. H. Bates, Lake City, read an excellent paper on tetanus in minor and industrial surgery, giving a detailed report of several cases in which the use of anti-tetanus serum had resulted in the cure of those that seemed hopeless. A general discussion followd this paper. Dr. D. E. Cline, Wellborn, presented a most interesting case of congenital heart disease in a girl of about six years of age.

The name of the joint society was discussed and a motion made and carried to change it to the Suwannee River Medical Society.

A rising vote of thanks was tendered Senator Hinely for the use of his club house, and to the doctors of Suwannee County for their genial hospitality and for the good dinner, after which the society adjourned, to meet in Lake City in April. The doctors present were: H. F. Airth, T. S. Anderson, L. M. Anderson, L. J. Arnold, R. A. Barnett, T. H. Bates, Jas. J. Beaty, I. A. Black, A. L. Blalock, J. R. Bruce, Herbert Caldwell, D. E. Cline, D. N. Cone, J. H. Corbett, Geo. C. Davis, R. E. Dicks, J. H. Dyer, P. C. Parnell, John D. Gable, R. B. Harkness, W. M. Ives, Eustace Long, W. S. Nichols, J. M. Price, H. M. Strickland and W. C. White.

Dr. S. B. Bieker, of St. Petersburg, and Dr. Anette Mebane, of Memphis, Tenn., were married February 16th, at Memphis, Tenn.

Dr. George A. Munch, convicted head of a diploma mill, said to have been operated since 1921, was sentenced to five years imprisonment in the federal prison at Atlanta and a fine of $1,000 in federal court on March 18. Notice of an appeal was filed by defense attorneys.

Government attorneys recommended a nolle prosse in the cases against Charles W. Page, Chipley; Samuel McCubbin, Kansas City; Benedict Lust, New York; William A. Lucia, Brooklyn; Francisco P. Trapini, New York; Paul C. Ronning, West Palm Beach, and Edward J. Roach, Ormond Beach, who were granted severances when the case was called for trial Monday.

Maximum penalty for use of the mails to defraud, the crime for which Dr. Munch was convicted yesterday, is five years in federal penitentiary and $10,000 fine. In imposing sentence, Federal Judge Lake Jones said the law did not provide a penalty severe enough for the crime of which this defendant has been convicted.

"I have no idea of mercy in imposing this sentence," Judge Jones said, "but I have decided not to make it as severe as I could, because it is not the place of this court to punish the defendant for anything except an active violation of the postal laws."

Action against Dr. Munch's seven co-defendants, who were acquitted yesterday, and the seven who were granted severance, may be taken by the federal authorities, officers said today. The action would be based on procuring drugs as a doctor through the medium of a false license.

The appeal of Dr. Munch will be taken to the circuit court of appeals for the fifth district, at New Orleans.

Dr. L. M. Anderson, of Lake City, now has offices in the Blanche Hotel Annex. Dr. Anderson does general medicine.

A daughter was born February 21st, 1927, to Dr. and Mrs. J. C. Chandler, 207 Memorial Highway, Tampa.

Dr. Allen M. Ames and Miss Faye Jernigan were married in Pensacola February 23, 1927. They spent their honeymoon in New Orleans during the Mardi Gras.

The following program was rendered during the March and April meetings of the Pinellas County Medical Society, St. Petersburg:

"Ectopic Pregnancy" — Dr. B. T. Prather. Discussion opened by Dr. Ray Davies.

"Significance of Pain in Lower Back"—Dr.

T. B. Echard. Discussion opened by Dr. L. Lambdin.

"Present Status of Organized Medicine in Florida"—Dr. H. Mason Smith, Tampa.

"Precordial Pain"—Dr. C. A. Williams. Discussion opened by Dr. N. M. Marr.

"The Place of Diet and Insulin in Diabetes"—Dr. F. F. Kumm. Discussion opened by Dr. R. H. Knowlton.

"Duodenal Ulcer from the Standpoint of the Surgeon"—Dr. L. A. Wylie. Discussion opened by Drs. A. P. Roope and W. G. Post.

"Duodenal Ulcer from the Standpoint of the Internist" — Dr. H. W. Wade. Discussion opened by Drs. A. P. Roope and W. G. Post.

The Wey building in Arcadia was burned during the past month. Drs. D. L. McSwain, H. P. Bevis, C. C. Witt, C. H. Kirkpatrick and C. P. Sandusky occupied offices in this building and unfortunately suffered considerable loss.

Dr. I. A. Black, of Lake City, announces the opening of offices in the Blanche Hotel Annex, specializing in Eye, Ear, Nose and Throat.

Dr. and Mrs. L. L. Dozier, of Tallahassee, announce the arrival of a son, born at the St. John's hospital February 1st, 1927.

Dr. Clancy M. Jackson, formerly physician for the Duval County Welfare Board, and who had been practicing for some months at Flint Rock, where he was surgeon for the Standard Lumber Company, was found dead on a road near Fanlew March 11th, and presumably had been murdered for the purpose of robbery. Dr. Jackson was thirty-four years old. He was a member of the Duval County Medical Society and the Florida Medical Association. He is survived by his wife, a son, a sister, Mrs. L. M. Napier, and his father, Dr. C. H. S. Jackson, of Jacksonville.

Dr. W. E. Van Landingham has been recently appointed city health officer for West Palm Beach. Dr. Van Landingham is the new first vice president of the Florida Medical Association and was chairman of the local committee of entertainment at the fifty-fourth annual meeting of the Association. He will fill a very important place in the health center for the city of West Palm Beach.

Since the last Journal was published, the following component societies have reported 100% of their membership dues paid for the calendar year 1927. The secretaries and treasurers are to be congratulated on the splendid showing of their societies. One reason the state association is showing unusual strength is because of the growing strength in the component societies:

Bradford County Medical Society.
Brevard County Medical Society.
Broward County Medical Society.
Duval County Medical Society.
Hamilton County Medical Society.
Lee County Medical Society.
Madison County Medical Society.
Monroe County Medical Society.
Pinellas County Medical Society.
Polk County Medical Society.
St. Johns County Medical Society.
Seminole County Medical Society.
Suwannee County Medical Society.
Walton-Okaloosa County Medical Society.

Dr. C. H. Farmer, member of the Polk County Medical Society, was recently appointed city health officer for Lakeland. Dr. Farmer has had particular training as a health officer, having served in South Carolina and also with the State Board of Health in Florida before taking up general practice in the city of Lakeland.

Dr. M. A. Hubert, who has been practicing at Sebring for the past year, has moved to Avon Park and opened offices for practice.

A splendid service was rendered by Dr. W. McL. Shaw, of Jacksonville, who kept his daylight lantern machine in constant readiness at the annual convention for those on the scientific program who desired to show slides in connection with their papers. It was considerable effort and work to carry this machine from Jacksonville to West Palm Beach, and the service was rendered without compensation, and very much appreciated by Dr. Barker, our invited guest, and others on the program who accepted this splendid service.



Annual Banquet of the Duval County Medical Association, at George Washington Hotel, March 1, 1927, Jacksonville, Fla.

ANNUAL DINNER DUVAL COUNTY MEDICAL SOCIETY

Tuesday evening, March first, at the Hotel George Washington, in the City of Jacksonville, was held the annual dinner of the Duval County Medical Society. This dinner took the place of the regular monthly meeting of the society, being held on the same evening at the same hour. Physicians from points in Georgia and Florida were extended invitations by individual members, and the society had as its invited guests the superintendents of Jacksonville hospitals, the resident physicians of the same, the business manager of the Journal and the presidents of all component county medical societies in the State.

The guest of honor and principal speaker on this occasion was Doctor Edward Starr Judd, of Rochester, Minnesota, who delivered a classic and highly interesting address on "The Surgery of the Biliary Passages", profusely illustrated by lantern slides.

Covers were laid for about two hundred. Two of Jacksonville's artists, Mrs. Theo. G. Croft and Mr. Don Ferrandou, contributed largely to the success of the dinner and were most generous in their response to repeated encores. The orchestra of Mr. Leo Kitchen rendered selections throughout the evening.

At the speakers' table with Doctor Judd, in addition to President Louie Limbaugh, who presided, and Doctor Knox Simpson, who introduced the speaker, were: Doctor H. Mason Smith, President of the Florida Medical Association; Doctor Herrman H. Harris, immediate Past-President Duval County Medical Society; Doctor S. E. Driskell, Vice-President of the Society; Doctor Kenneth Morris, Secretary, and Doctor W. M. Shaw, Treasurer.

A meeting of the Atlantic Coast Line Railway Surgeons was held at St. Petersburg, February 20th, and the following program rendered:

"Six Cases of Tetanus"—Dr. T. H. Bates, Lake City.

"Complications That May Arise from Injuries to the Temporal Bond—with Case Reports"—Dr. J. B. Parramore, Jacksonville.

"The Traumatic Sacro-iliac Joint"—Dr. R. R. Killinger, Jacksonville.

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held a meeting at the Court House, Monticello, March 9th, at 3 p. m. Several scientific papers were read. Dr. W. L. Funkhouser, specialist in diseases of children at Emory University, Atlanta, was principal speaker.

The Marion County Medical Society issued invitations to the medical men and their ladies representing five county societies of Central Florida, to a dinner which was held at the Hotel Marion in Ocala on the evening of March 17. There were present twenty-two physicians, representing the county societies of Alachua, Lake and Marion. Dr. H. Mason Smith was the speaker of the evening. Dr. Smith, in his address, pleaded for better organization and cooperation among medical men. Dr. Albert H. Freeman, president of Marion County Medical Society, acted as toastmaster. After the ladies had retired to the parlors of the hotel, Dr. Freeman announced the purpose of the meeting, viz.: To discuss the reorganization of the Central Florida Medical Society. The subject was discussed freely, and all were unanimous in the opinion that a reorganization should be effected.

Dr. G. C. Tillman, of Gainesville, was elected president. Drs. M. M. Hannum, Eustis; A. H. Freeman, Ocala, and W. C. Thomas, Gainesville, were elected vice-presidents, and Dr. J. L. Chalker, Ocala, secretary-treasurer. The meeting dates are twice each year, in February and October. The next meeting goes to Gainesville in October. It was decided that no physician would be accepted for membership who is not a member of a county medical society; that the Central Florida Medical Society must not replace or conflict with local county societies or the State Medical Association. The Florida State Medical Journal was designated as the official journal.

The wives of the physicians of the counties represented also went into executive session and organized a Ladies' Auxiliary to the Central Florida Medical Society. Mrs. J. N. Moore was elected president, Mrs. T. K. Slaughter, vice-president, and Mrs. E. G. Lindner, secretary.

The Scientific Program committee should be congratulated on the program prepared and the interest which was evidenced by the attendance. This was particularly noticed the afternoon of the last day. A count of those present, as the last paper was read, indicated about three times as many in attendance as during the last meeting of the previous year. Those who prepared papers should certainly feel encouraged to find so many members who stayed until the entire program was completed.

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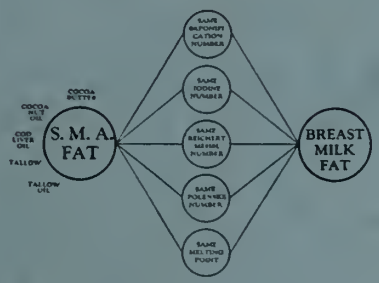
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CONTENTS

PAGE

On the Relation of the Functions of the Glands of Internal Secretion to the Thinking, the Feeling, and the Striving of Man 254
Lewellys F. Barker, M.D., Baltimore, Md.

Mechanical Aids in Estimating Cardiac Reserve . 261
Herbert Caldwell, M.D., Lake City.

Treatment of Heart Disease 263
Meredith Mallory, M.D., Orlando

PAGE

Congenital Hypertrophic Pyloric Stenosis . . . 268
Edward Jelks, M.D., F.A.C.S., Jacksonville

Editorials: (1) Joseph Yates Porter. (2) Medical Examiners Get Results. (3) Workmen's Compensation Bill 272-274

State News Items 275

Schedule of Meetings, Component Societies of Florida Medical Association, Inc. xviii

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PUBLISHED MONTHLY

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ON THE RELATION OF THE FUNCTIONS OF THE GLANDS OF INTERNAL SECRETION TO THE THINKING, THE FEELING, AND THE STRIVING OF MAN.*

LEWELLYS F. BARKER, M.D.,
Baltimore, Maryland.

When your President, Dr. H. Mason Smith, honored me with the invitation to address you at this annual session, and asked me to speak upon some subject that I thought would be of interest to general practitioners, I decided to devote my remarks to "The Relation of the Functions of the Glands of Internal Secretion to the Thinking, the Feeling, and the Striving of Man."

In selecting this topic, I recognize its dangers. Not only in medical literature but also in lay literature there has been an inclination on the part of some to go far beyond actual knowledge in this domain and to indulge in the most fanciful speculations. This unbridling of fantasy has led to a profound reaction in the medical profession, so profound indeed that there have been some who look upon the rise of endocrinology as a "fiasco" and who would appear to regard even conservative discussions of the topic as ill-timed if not actually unethical!

Both attitudes represent extremes. Uncritical enthusiasm is certainly to be deprecated; but pessimism that is blind to genuine advances in an important field is similarly blameworthy. *In medio tutissimus ibis.* In the hope that an appraisal of the actual status of one phase of endocrinological research, namely the influence of the internal secretions upon the human psyche, might prove interesting to this audience, I have decided to limit my remarks to a brief discussion of it.

Every practitioner is more or less familiar with the classical endocrine syndromes and with the fact that these syndromes are made up not of physical symptoms and signs alone but also of mental symptoms—disturbances of thinking, of feeling and of striving. Moreover, all practitioners meet from time to time with outspokenly psychotic patients, some of whom have to be sent to closed institutions because of the better treatment that they can receive there and because of the difficulty in caring for them outside; careful studies of such psychotic patients not infrequently reveal evidences of coexisting endocrine disturbances. This association of mental disturbances with major endocrine syndromes, on the one hand, and of endocrine disturbances with major psychiatric syndromes, on the other, can scarcely be any accident. We can here be fairly sure of the existence of causal relationships and it is certainly our duty earnestly to seek for them.

*Read by invitation before the meeting of the Florida State Medical Association, held at West Palm Beach, Florida, April 5th and 6th, 1927.

DISTURBANCES OF THINKING, OF FEELING AND OF STRIVING OBSERVABLE IN ASSOCIATION WITH OUTSPOKEN DISEASES OF THE ENDOCRINE GLANDS

Among the glands of internal secretion, those that have been best studied are the thyroid, the parathyroids, the hypophysis cerebri or pituitary gland, the epiphysis cerebri or pineal gland, the islands of Langerhans in the pancreas, the thymus gland, the chromaffin system of the suprarenal glands, the interrenal system of the same glands, and the gonads or genital glands.

Diseases of certain of these glands are far better understood than are those of others of the group. Thus we know most, perhaps, regarding the symptoms that accompany diseases of the thyroid, of the parathyroids and of the hypophysis cerebri. Gradually, however, the symptoms referable to disturbance of the internal secretory functions of the pancreas, of the suprarenals, and of the gonads, are becoming better understood also. Time will not permit me to discuss the symptomatology of all the endocrinopathies, but with your consent I shall choose a few of the more outstanding clinical pictures, laying especial emphasis upon the abnormal psychic manifestations that are a part of them.

Starting with diseases of the *thyroid* gland—the thyroepathies—you will recall that there are two striking clinical pictures not infrequently encountered: (1) Graves' disease, or exophthalmic goiter, which is believed to be due to an over-function of the gland; and (2) myxedema, due either to absence of the gland or to under-function thereof. In exophthalmic goitre the

main symptoms are the protrusion of the eyeballs, the enlargement and pulsation of the thyroid gland known as goiter or struma, the fine tremor of the fingers, the increased pulse rate, the tendency to loss of weight, the evidences of vasomotor instability, the look of anxiety on the face, the hurried restless movements exhibited, the hypersensitiveness to mental stimuli, the irritability, the restlessness, the sleeplessness, and the marked acceleration of the basal metabolic rate. Patients suffering from this malady often exhibit also character anomalies; sometimes they suffer from pathological fears, obsessions, or ideas of injury; occasionally, they show marked excitement not unlike that seen in hypomanic states. In myxedema, on the other hand, in which we have to deal with under-function of the thyroid gland, the patients present an entirely different physical appearance and a strikingly different mental state and behavior. The skin is dry and wrinkled, the hair tends to fall out, there is a tendency to obesity, digestion and excretion are slowed, the voluntary movements are slow, stiff and clumsy, there is sensitiveness to cold, the facial expression is apathetic and quiet, the patients seem drowsy and dull, their thoughts come slowly, their emotional reactions are sluggish, and, finally, determinations of the basal metabolic rate reveal a retardation much below the normal.

Now, though the disturbances of thinking, feeling and striving to which I have referred are frequent in Graves' disease and in myxedema (though very different in the two conditions), it is relatively rare that outspoken psychoses occur either with over-function or under-function of the thyroid gland; and, when they do occur, these psychoses appear to have their origin in an associated psychopathic inheritance rather than in the endocrine anomalies alone. This has been so not only in my own experience but in that of many authors who have made a careful study of the relationships (Massarotti, 1914; McCord and Haynes, 1917; and Foss and Jackson, 1924.)

On removal of the *parathyroid* glands at surgical operations for goiter (before the baneful effects of parathyroidectomy were known) tetany often developed. Sometimes parathyroid insufficiency arises independently of surgery and gives rise to the same tetany syndrome. Every practitioner must have seen, at one time or another, a case of tetany with its typical tonic spasms. You will recall the peculiar form assumed by the hand (the so-called "obstetrical hand"); or, perhaps, spasms of both the hands and the feet (the so-called "carpo-pedal spasms"). The electrical excitability of the muscles and the nerves is increased, as can be readily shown by exact measurements. Moreover, there is increased mechanical excitability of the muscles and nerves in tetany, for if we percuss over the facial nerve, contractions will occur in the muscles innervated by all three divisions of that nerve, or if we compress the nerves of the upper arm we can elicit flexion of the forearm and a typical obstetrical hand (the so-called "Trousseau's sign"). When parathyroid insufficiency has lasted for a long time (chronic tetany) marked disturbances of nutrition become manifest, including defects of the enamel of the teeth, perinuclear cataracts, and certain abnormal mental states (irritability, fatigability, drowsiness). The calcium content of the blood is diminished and the acid-base equilibrium is abnormally unstable in tetany. Outspoken psychoses are, however, rare in association with tetany; though they may occur in association with parathyreopathies, they are, like those that are associated with the thyreopathies, to be explained rather by some special disposition of the nervous system (hereditary or acquired) than by the associated parathyreopathic influence.

In diseases of the *pituitary gland* (*hypophysis cerebri*) we may see, on the one hand, acromegaly due to over-function of the gland or, on the other, dystrophia-adiposo-genitalis (Fröhlich's syndrome) due to under-function of the gland. You doubtless all recall the main features of acromegaly—the enlargement of the hands and feet, the prominent up-curved chin, the projecting malar bones and prominent supra-orbital arches, the hexagonal-shaped face, the so-called "nut-cracker" profile, and the marked kyphosis. The disease develops gradually; the patients notice that they have to use larger shoes, to buy larger sized gloves and larger sized collars and hats. In association with acromegaly there may be marked mental disturbances, most frequently of a hypomanic character (tendency to push of talk, acceleration of movements and thought, egocentricity, etc.). When there is under-function of the pituitary gland (as in dystrophia-adiposo-genitalis) we meet with a peculiar form of obesity, in which the fat tends to accumulate in the proximal portions of the extremities, about the breasts and about the ab-

domen. Upon the surface of the body there is less hair than normal (hypotrichosis), and if the hypopituitarism has existed in childhood the axillary hairs and the pubic hairs do not develop. The menstrual function may not appear, or, if it appears, there may be long periods of amenorrhœa. The psyche of these patients is nearly always subnormal. They may be happy, sometimes indeed they are a little elated, but there is nearly always some slight reduction of the mental powers—the judgment is poor and there are periods of drowsiness and mental dulness.

Paul Büchler (1923) has discussed the psychic disturbances met with in the course of these diseases of the pituitary gland. He emphasizes the fact, now well-known, that lesions in the floor of the third ventricle may give rise to clinical pictures very similar to those due to diseases of the pituitary gland itself. Certain cases of pituitary diseases run their course without marked psychical peculiarities, others show slight psychical defects, and only a few exhibit well-defined psychoses. When psychoses of the manic-depressive type or of the schizophrenic type appear in the course of hypophyseal disease they are, in my opinion, dependent upon constitutional anomalies other than the endocrine disturbance.

That, however, hypomanic states may be due to over-function of the pituitary gland and that a moderate grade of imbecility may depend upon under-function of the pituitary gland are facts that seem to me to be well founded.

Deficiency of the endocrine function of the *pancreas,* the cause of diabetes mellitus, in which the sugar in the blood is markedly increased and sugar goes over into the urine, may be accompanied by mental disturbances, but these disturbances are so irregular that in most cases their relations to under-function of the cells of the islands of Langerhans are not clear. The psychic manifestations of the presence of an excess of the internal secretion of the pancreas (hyperinsulinæmia) in the blood are well seen in the so-called hypoglycæmic crisis or insulin shock, in which the patient may go to sleep and remain asleep for several hours—a form of narcolepsy with which we have become quite familiar since the advent of insulin therapy for diabetes mellitus.

Much stress has been laid upon the relation of the internal secretion of the *sex glands,* or *gonads,* to human thought, feeling and behavior. In this connection, the study of eunuchs (castrated persons) and of eunuchoids (persons in whom the gonads do not develop normally) has been very illuminating. When the testicles are removed in childhood, the body and mind develop somewhat abnormally. A special sect in the Orient—the so-called Skopzi—castrates many of its males in youth, and the bodily and mental characteristics of the eunuchs that result have been thoroughly studied by Tandler and Grosz. Similar bodily and mental phenomena are met with in eunuchoids. In such persons (both eunuchs and eunuchoids) the extremities grow to be unusually long, owing to failure of the epiphyses of the long bones to unite at the proper time with the diaphyses; the hair upon the body shows an abnormal distribution; and the patients look drowsy and are apathetic. Some of them manifest anti-social or asocial behavior; thus, they may exhibit criminal tendencies, and they exhibit a peculiar taciturnity and a tendency to seclusion. Here we see exemplified, apparently, disturbances of "feeling" and of "will," due to deficiency of an endocrine product.

That the functions of the reproductive organs in the female, also, have a definite influence upon mental states is well-known, not only to every physician but also to every layman. The relations of menstrual periods, on the one hand, and of the menopause, on the other, to disturbances of the psyche in women can scarcely have been overlooked by any person of experience.

The human *suprarenal gland* consists of two parts, the medulla, which manufactures epinephrin (adrenalin), and the cortex, which corresponds to the interrenal gland of certain lower animals. In diseases of the suprarenal gland, the symptoms that develop depend upon whether the medulla or chromaffin part, the cortex or interrenal part, or both parts, are diseased and to what extent. The epinephrin produced by the medullary portion of the suprarenal gland is a sensitizer of the sympathetic nervous system. When there is under-activity of the medulla of the suprarenal gland, vagotonic states may develop, because of the under-activity of the opposing sympathetic which results from the diminished production of epinephrin. When the medulla of the suprarenal is over-active, however, the phenomena of sympathicotonia may develop; the blood pressure in such patients tends to be higher than normal. When the cortex (inter-

renal portion) of the suprarenal gland is deficient in its internal secretion, Addison's disease makes its appearance with its well-known symptoms—weakness, low blood pressure, digestive disturbances, and pigmentation of the skin and mucous membranes. In this disease, the patients often exhibit anxiety, fear, and a tendency to querulousness. When, on the other hand, there is over-activity of the cortex of the suprarenal glands, due either to hyperplasia or to the presence of tumor (hypernephroma), the clinical syndromes that result vary with the time of life at which the over-activity of the cortex appears. Thus, if it occur during intra-uterine life, the child born is a "pseudo-hermaphrodite," the sex organs resembling both those of the male and those of the female. If the over-activity occur in early childhood, we meet with those peculiar states known as "premature puberty," in which little girls or little boys develop the bodily sex characteristics and the sexual mental states of maturity. But, if the over-activity of the suprarenal cortex do not develop until adulthood, we may see a peculiar transformation in both somatic and psychic domains, particularly in women, who may grow beards, moustaches or may develop hair all over their bodies (hirsutism) and become markedly vigorous and masculine in type (virilism). The "bearded ladies" of the side-shows are examples of such suprarenal virilism.

I could go on to other instances of mental disturbance associated with still other endocrinopathies, but those already cited will perhaps illustrate well enough the principle under discussion.

It should be borne in mind, especially, that the internal secretions stand in very close relation to the functions of the vegetative nervous system (sympathetic and para-sympathetic), and that the latter in turn are closely related to emotional states, a fact that probably accounts for the association of abnormal moods and of anomalies of character and temperament with the more outspoken diseases of the endocrine organs.

ENDOCRINE SIGNS AND SYMPTOMS OBSERVABLE IN PATIENTS SUFFERING FROM MAJOR PSYCHOSES AND IN THOSE MANIFESTING IDIOCY OR IMBECILITY

Because of the similarity of some of the mental states met with in endocrine disease to certain of the psychoses and certain of the mental deficiencies, the conception gradually arose that the endogenous psychoses themselves and perhaps the congenital psychic inferiorities could in one way or another be proven to be dependent upon endocrine abnormalities. This view has stimulated both clinicians and pathologists to careful studies of symptomatology on the one hand and of autopsy findings on the other. Let us see in how far the conception is borne out by the facts thus far accumulated.

Take for example the form of mental disorder known as *manic-depressive psychosis*. Persons suffering from this psychosis may exhibit either a melancholic state or a manic state, or they may manifest first one and then the other (as in the circular types). In melancholia, the sad expression of the face is very characteristic; the patient looks down rather than up, the angles of the mouth are drawn down, the wrinkles in the face are increased, and the patient cannot smile, but weeps on slight provocation. There is loss of interest, inability to concentrate, and a feeling that life is not worth living. Along with these symptoms, there is a tendency to self-blame and to outspoken ideas of unworthiness, of poverty and, perhaps, of actual sin. The mental torture suffered by these patients is so unbearable that frequently they try to end their lives; indeed, in severe cases, the patients must be watched closely if suicide is to be prevented. In the manic phase of the manic-depressive psychosis, the symptoms are of a precisely opposite nature. The patients are elated, or exalted, rather than depressed. Their thoughts come quickly. They speak and move rapidly. Everything is easy for them; nothing seems to be any effort. They exhibit "pressure of activity" and they feel that they have great power. Physicians meet with every gradation from the milder forms of maniacal excitement to the severer forms in which the patients become actually furious, tearing the clothes from their bodies and injuring themselves or others. In the circular forms of the manic-depressive psychosis, in which the same patient at one time exhibits a melancholic state, at another a manic state, we have opportunity to observe one of the most marked contrasts that human life affords.

Just here let me call your attention to the fact that, among people who are not actually insane, there may be an inborn tendency to similar transitions from states of mild elation to states of mild depression, the so-called mild *cyclothymic states*. Indeed, many of the persons whom we

think of as being very well and very happy are in reality very slightly hypomanic, whereas many of the people we know who are moody, taciturn, and a little sad and seclusive are persons of hypomelancholic trend, in both instances because of inherited elation-depression constitution.

The more I see of *psychoneurotic states* (inclusive of neurasthenic states, and psychasthenic states), the more I am impressed with their possible relationships to the cycloid constitution on the one hand or to the schizoid constitution on the other. Environmental influences are of course important in the production of these states, but in almost all instances the study of family histories reveals evidence supportive of the idea that inherited constitutional dispositions may be even more important than the environmental factors.

The similarity of milder manic states to the mental disturbances met with in exophthalmic goiter and the resemblance of the milder depressive states to the apathy, depression, and slowness of thought and movement characteristic of myxedematous patients naturally led many to think of the possibility that the manic-depressive psychosis itself may be thyreopathic in origin. But careful studies of thyreopathic patients on the one hand and of manic-depressive patients on the other yields very little evidence for the view that the elation and depression of the manic-depressive psychosis are due to disturbances of the thyroid function. There is always danger in assuming genetic relationship merely because of similarity of symptomatology. One cannot be too careful to avoid being led into false ideas of etiology on such grounds.

Let us consider next the group of deteriorative adolescent psychoses known as *dementia praecox* or *schizophrenia*. The idea that the origin of dementia præcox is to be sought in disturbances of the internal secretion of the gonads has been widely disseminated, but in my opinion without sufficient reason. The onset of dementia præcox at the puberty phase of development lent color to the view.

For a time, too, studies with Abderhalden's reaction seemed to support the idea. Later investigations have shown the fallacy of relying too much upon Abderhalden's reaction in etiological studies.

Moreover, though the internal secretion of the gonads does play a part, and a very important part, in producing bodily and mental changes at the period of puberty, leading as it does to an erotization of the body, it must be borne in mind, as R. Fischer has emphasized, that the puberty psyche is a much more complex affair than mere erotization. Again, it should not be forgotten that the onset of schizophrenic psychoses need not necessarily coincide with the advent of puberty and adolescence.

As you know, it has been customary to divide patients suffering from dementia præcox into three main groups: (1) the *hebephrenics*, (2) the *catatonics* and (3) the *paranoid dements*. In all three groups there are evidences of dissociation of the personality—of disharmony between the life of feeling and the life of thought; often the psychomotility is in disagreement with the total psyche. The patients are apathetic and negativistic; they often exhibit rigidity of the musculature, stereotyped movements or attitudes, and bizarre, unaccountable behavior; often, too, they have hallucinations—they hear voices, see visions; and they may harbor delusions, especially pathological ideas of persecution.

Schizophrenic patients may, it is true, show some signs and symptoms of endocrine disturbance, but these need not be marked; and, moreover, from endocrinopathies alone we never see the clinical picture of hebephrenia, of catatonia or of paranoid dementia. In dementia præcox there appears to be an inherited disposition to the disease, a disposition that involves the central nervous system itself in addition to any congenital abnormalities of endocrine or other organs that may coexist.

Attempts have been made by some to bring *idiopathic epilepsy* into the domain of the endocrinopathies; but here, again, I believe that enthusiasm has outrun available facts. There are, it is true, certain endocrine diseases in which there is a tendency to elementary spasm; but, in my opinion, constitutional or idiopathic epilepsy is far too complex a problem to be explained by any endocrine data that are as yet at our disposal.

The psychoses met with in association with various infections and intoxications, so-called *toxic-infectious psychoses* or *exogenous reaction types of Bonhoeffer*, are striking in that the mental phenomena resemble one another very closely, even when the known exogenous etiological factors are quite dissimilar. This has led some investigators to believe in the existence of preformed mechanisms that come into play under

the influence of various exogenous injuries. The plausible hypothesis has been suggested that certain constitutional links must be interpolated between the poisons from the outside and the neuropsychic reactions that result, and it has been held possible that the endocrine glands are those links—that, in other words, the glands of internal secretion may be responsible for such transformation of heterogeneous stimuli as will account for the similarity of the reactions exhibited in very different intoxications and infections. If this view be true, it is tantamount to saying that the external poisons do not act so much upon the brain directly as indirectly through the intermediation of the endocrine glands. The suggestion is an interesting one and worthy of careful test, though it should not yet be accepted as demonstrated.

More popular still is the idea that *idiocy and imbecility* are directly related to endocrine deficiency of one sort or another. The fact that acute thyroiditis may develop as a complication of infections in childhood, the fact that the pituitary gland is often involved in hereditary syphilis, and the fact that the thymus gland may be implicated in diseases of early life, particularly in persons who later on exhibit signs of imbecility or idiocy, has seemed to lend some corroboration to the view of an endocrine origin of at least part of the congenital mental deficiencies and especially of those that are acquired in very early life.

In the examination of cretins, goiter and signs of thyroid insufficiency are common findings; but cretinism is something more than mere thyroid insufficiency and myxoedema of childhood is by no means identical with endemic cretinism. The administration of thyroid extract in cretinism is of some value but it does not help a cretin so much as it will help a child who suffers from simple myxoedema.

Various attempts have been made to establish relationships between thymic defects and epileptic idiocy, between defects of the pituitary gland and erethic forms of imbecility, and between defects of the thyroid and parathyroid glands and so-called Mongoloid idiocy. These researches, though interesting, are still in flux, as are those bearing upon the possible endocrine origin of spasmophilia, of achondroplasia and of other disorders met with during development.

You must have met in the medical literature frequently with the term "endocrine formula" as applied to constitutions and personalities. But because this term "endocrine formula" has been introduced into the literature, you should not be deceived into thinking that the determination of the endocrine formula of a constitution or a personality is any easy matter.

Moreover, you must, all of you, by this time have become well acquainted with the fallacies of the much-vaunted endocrine therapies for mental deficiencies and for psychotic states. Nothing seems to me much more tragic than the necessity of disappointing the hopes of a pair of fond parents with regard to the discovery, by their physician, of the needed endocrine products to remove the imbecility of their child!

CONSTITUTION, TEMPERAMENT, CHARACTER AND ENDOCRINE MAKE-UP

The tendency of internal medicine today is to study single persons from the standpoint of biology. Indeed, internal medicine might, perhaps, be defined as "the study of the biology of single persons." One clinician (Brugsch) has adopted "personalism" as a clinical slogan. Certainly no two human beings are precisely alike. We have to think of each person as the resultant of a series of interactions of environmental factors with the germ plasm derived from his two parents (in the fertilized egg-cell or zygote). Biologists speak of the inherited portion as the "genotype" and of the acquired portion as the "paratype," the resultant of the interaction between paratype and genotype being the "realized person" or "phenotype." The complete understanding of any human person, that is to say of any human phenotype, would theoretically necessitate, therefore, a complete knowledge of his genotypic pattern on the one hand and on the other of all the environmental or so-called paratypic factors that have interacted with this genotypic pattern.

These applications of modern biology to the study of man have lead to a pronounced revival of studies of "constitution." Constitutional studies interested older clinicians markedly, though they temporarily suffered eclipse through the brilliant results of the bacteriological and the parasitological researches of the last fifty years. Now, studies of constitution are again coming into their own, and, with them, studies of temperament, of character, and of the things that determine them.

In reading the medical literature in this connection, I would warn you, however, that no

uniformity of terminology has, as yet, been arrived at, and that the terms "constitution," "temperament," "character" and "habitus" are defined in different ways by different writers. Some of the French writers, notably Landonzy and Roger and Laignel-Lavastine, define constitution as the "morphological mode of the individual reactional coefficient"; temperament as the "physiological mode" of the same, and character as the "psychological mode" of the same. Others again reserve the term "constitution" for the genotypic constituents of the organism; whereas still others make the constitution include the whole psycho-physical make-up of any given phenotype at the moment of its study (thus including both genotypic and paratypic factors). Without stopping to discuss the relative merits of these different definitions, I may say that a great deal of interest has recently been aroused in the relationships of the physical constitution (habitus) to temperament and character (physiological and psychological reaction types). In this connection, the book of George Draper on "Human Constitution," (1924), that of Kretschmer on "Physique and Character," (1925), and that of Wertheimer and Hesketh, entitled "The Significance of the Physical Constitution in Mental Disease," (1926), have drawn our attention to varieties of physical constitution and their relation to varieties of character and of temperament on the one hand and to types of mental disease that may develop in persons possessing them on the other. Thus when the physical constitution has the form of the so-called pyknic or apoplectic type, in which the face is round or pentangular and there is a tendency to obesity and to high blood pressure, there is said also to be a tendency to develop the cycloid or extrovert type of personality. In other words, persons of the pyknic habitus are likely to be good mixers, for they look out and not in, they are not shy and sensitive but instead are rather easy-going, getting along well with other people, vibrating as it were in sympathy with their surroundings. In case they should develop mental disease it is frequently of the manic-depressive type.

An opposite type of physique is the so-called asthenic habitus in which the face tends to be oval or elongated, the neck and extremities long and slender, the chest flat, and the abdominal viscera ptosed. Persons of this type tend to be thin rather than stout and are likely to have low blood pressure. Their personalities are often of the schizoid or introvert type rather than of the cycloid or extrovert type, that is to say they tend to be shy and shut in. They do not always get on well with those about them, they are inclined to go their own way independent of others, and, accordingly, are not very good mixers. They may, however, make good students and often develop into distinguished scholars or profound philosophers. Should they develop a psychosis, it is said to be more often of the schizophrenic type than of the manic depressive type.

One must not forget, however, that pure pyknic and pure asthenic types are less often met with than are alloys of the two types, for a person who is predominantly pyknic is often attracted by a person of the other sex who is predominantly asthenic! We might perhaps do well, as Bleuler suggests, in studying mental reaction types not to ask, "Is this person cycloid or is he schizoid?" but rather, "In how far is he cycloid and in how far is he schizoid in tendency?"

Aside from the asthenic and pyknic types of physical constitution there are many bizarre physical types to be observed, especially in persons in whom the organs of internal secretion have been abnormal during the developmental period. These bizarre types are sometimes spoken of as "dysplastic" types of physical constitution.

In how far these attempts to establish relationships between special types of physical constitution and special tendencies in mental reactions will prove to be helpful remains to be seen. The ideas are certainly interesting and worth following up; but we must not forget that the tendency is to lay too much, rather than too little, emphasis upon new conceptions. One should be very cautious and very critical in following the literature in this new field and in making applications of these newer ideas in one's own clinical studies. Certainly the revival of interest in human constitution and in the relationship of constitution to disposition to disease is to be welcomed. I think that there is relatively little danger of our underestimating the influence of exogenous etiological factors. Certainly, up to very recently, we have given too little attention to possible endogenous factors in disease. You will find it interesting, if you have not already attempted it, to see whether or not you can

(*Continued on page 274*)

MECHANICAL AIDS IN ESTIMATING CARDIAC RESERVE*

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When a heart functions properly, it maintains a flow of blood sufficient for the needs of all the tissues of the body, at rest or during exercise.

The difference between the amount of work which a given heart does at rest, and the greatest amount of work it is capable of doing under stress is its cardiac reserve.

Breathlessness, cyanosis, cardiac pain and pulsus alternans are signs that the heart has been overtaxed, but it is our endeavor to be able to select the patients who will quickly develop these symptoms without having them actually occur. If these signs appear when the patient is at rest, the reserve force of the heart is approaching zero.

Anatomically, the heart, that engine which drives the body from the cradle to the grave, yields up its secrets, yet its capacity for work under stress seems as difficult to determine as is the long-sought habitat of the soul.

Recently much work has been done along the lines laid down by Henderson and Haggard—in what is known as the gasometric method—estimating the various gases in the blood at rest, and after exertion. Their method seems to open a road to success, but is entirely without the bounds of this paper.

In 1922, Brittingham and White[1] showed most satisfactorily the fallacy of depending on the effect of exercise on blood pressure or pulse in determining cardiac functional capacity.

What, then, is the reason for this paper? It is twofold.

In the last few years, one of the well-known insurance companies of the country has adopted a plan for separating the bad heart risks from the good, especially in those cases not showing definite clinical evidence of heart failure.

The plan involves the use of a machine manufactured by a well-known firm, and which is rather widely advertised as possessing the merit of being able, if properly used, to enable one to estimate the functional capacity of the heart.

The first reason for this paper, then, is to set forth the findings of a number of examinations made with the spirometer and the results compared with other forms of exercise, and the findings of the electrocardiograph.

The second reason is that the writer, in an examination of this subject, having completed about one hundred tests with the spirometer, most of them checked with the electrocardiograph and exercise, has come upon certain reactions of the heart which seem worthy of reiteration at this time.

First. Exercise alone: No one set of exercises has been found that can be said to be all that is necessary, or that equally arouses the heart muscle to action. Schneider's Index, which is frequently quoted, stresses too much the rapid heart. Several patients with quite marked myocarditis were, however, able to satisfactorily pass this test, which is one of those advocated in the selection of aviators.

Although exercise frequently fails to show functional incapacity of the heart, the writer uses a routine set of exercises and increases their scope if any abnormality is detected.

Recumbent: Pulse and blood pressure.

Standing: Pulse and blood pressure.

Twenty-five hops on each foot: Pulse and blood pressure, and in questionable cases: 100 hops with pulse and blood pressure. If the patient undergoes this ordeal with normal reaction, his cardiac function is considered good.

The following points seem worthy of note:

A rise in diastolic pressure of from 10 to 15 m.m. was noted constantly when the patient rose to a standing position from reclining, although the systolic might vary little, if any.

Field and Bock[2] state that in the prone position the blood flow is increased 25% above that in the upright position. This seems to be almost entirely due to the lowered diastolic in the prone position, and gives a very good reason for confinement to bed of patients suffering with a highly diastolic pressure.

A heart that has been accustomed to prolonged exercise (the athlete's heart) frequently does not respond by increased pulse and blood pressure until the exercise is continued long enough to whip it into action—so that the heart, with failing functional reserve and the athlete's heart frequently give the same result after 50 hops; that is, a stationary or falling blood pressure. Increase the number of hops to fatigue, and the athlete's heart jumps to the work—the weakened heart shows increasing failure to meet the demands. A low systolic pressure with a small

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pulse pressure indicates that the heart itself is weak.

A small pulse pressure is alarming, and one in which this factor increases with exercise is an evidence of failing reserve.

T. F. Cotton says, "The exercise tolerance test is always poor with a considerably enlarged heart. With no enlargement and valvular disease, although the myocardium may be assumed to be not sound, the cardiac reserve may be very little impaired."

ELECTROCARDIOGRAPH

There are certain signs of failing cardiac reserve which the electrocardiograph does show, which are not possible to determine by other means. First: Inverted, or depressed, T waves, except when digitalis is being exhibited, mean myocardial weakness.

Delayed conduction time and prolonged excitation of the ventricles are signs of weakness. Heart block, complete or partial, is shown by this instrument and is a grave symptom. Beyond this there is a great difference of opinion as to the value of the electrocardiograph in estimating cardiac reserve.

F. W. Price[3] states: "It will thus be seen that clinical electrocardiography is the most precise means of investigating the functional efficiency of the myocardium itself."

A. W. Master and H. B. Pardee[4] state: "An abnormal electrocardiogram is indicative of a diseased heart, while a normal electrocardiogram is a sign of a fairly healthy muscle."

Paul D. White has recently stated: "I do not believe that the electrocardiograph can be used to estimate the functional capacity of the heart. Occasionally, with extreme weakness or disease, the complexes may be changed, but sometimes there is almost a normal electrocardiogram shortly before death."

These three opinions differ widely. White is an enthusiast about the electrocardiograph, and yet is willing to acknowledge its failure to detect a failing cardiac reserve.

The polygraph shows remarkably well pulsus alternans, which indicates a failing heart muscle, but this can also be detected while taking the blood pressure by the ausculatory method.

The polygraph also reveals delayed conduction time between the auricles and ventricles, a sign of grave significance.

This brings us to the consideration of the spirometer, a machine which its advocates believe will render possible the separation of the good from the bad risks in "that numerous groups of individuals, apparently in good health, who present, without other signs of diseases, a rapid pulse, irregularity of cardiac rhythm, a murmur of the functional type, a blood pressure higher or lower than usually conceded to be normal for their age and environment; or an unusual cardiac irritability with a rapid and extensive reaction to muscular exertion or psychic influence."[5]

It is also claimed for this instrument that the physician readily becomes expert in its use. That the patient quickly learns its few peculiarities, and the results are remarkably uniform for each phase of the test.

Briefly, the test has nine steps, but it naturally divides itself into two. First: What will the patient's heart do under increased thoracic pressure? Second: What will it do under decreased thoracic pressure?

Under increased pressure the blood pressure should drop, and this it does in the great majority of cases.

Under lessened pressure the blood pressure should rise, but this, in the writer's opinion, it does not do with sufficient uniformity to render the test of great value.

The advocates of this method claim that tests six, seven and eight are the vitally important ones. In this blowing test the blood pressure should rise from 20 to 50 m.m., and between these limits a rise is considered normal. They claim in a thousand cases such a uniformity of response that on the result of this test alone it can be decided which cases should be allowed insurance and which should not.

The writer's results were so varied that he finally selected five robust individuals of his acquaintance, athletically inclined and apparently normal, as a check, against the number of admitted cardiac cases—upon whom the test was being made.

Of these five only one gave the normal reaction expected on the first trial. When the trial was repeated, one more of the five was able to come within the normal limits.

This left three of these apparently healthy, strong individuals in the same class as patients with marked myocardial weakness. Yet, when these three men were subjected to prolonged exercise, their hearts responded with increased

blood pressure varying from 30 to 50 millimeters of mercury.

Among the cardiac patients examined, both functional and organic, the greatest number responded with a very slight increase of blood pressure, which would place them among the hypo-active group, or those of evident myocardial weakness.

A few had a very great response to the respiratory exercise, and a number of others, whose blood pressure seemed to be held down during the process of blowing into the spirometer, had a very great rise of blood pressure immediately upon inspiration.

This latter reaction, I believe, can be likened to the delayed rise spoken of by Brittingham and White, and is evidently a sign of cardiac fatigue approaching the limits of endurance.

Two cases during the test had a blood pressure approximating 210 cystolic, and the last two steps were omitted.

One patient's blood pressure, during the test, fell about 20 points, and this, with a very small pulse pressure, around ten and a slowing pulse, was considered sufficient reason for stopping the test. The patient's color remained good, but when asked later what his sensations were, he described a feeling of faintness and pain in the region of the heart.

In spite of a normal electrocardiograph, this last patient's test is considered the most conclusive made of a lessened cardiac reserve, and shows that the findings of the machine are, at times, very valuable. But the writer's conclusions in regard to the spirometer are:

First: That it is more difficult of manipulation, as regards the operator and the patient, than has been stated.

Second: That the results obtained are open to the same criticism as other exercise or cardio-respiratory tests, and that it does not supply a just basis upon which to grant or withhold insurance or compensation, and unless considered with a number of other facts, could scarcely be the deciding factor as to the amount of work a given heart was capable of doing.

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TREATMENT OF HEART DISEASE*

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Orlando.

In taking up the treatment of heart disease, one cannot help but call attention to the prevalence of this condition, for the death rate from cardiac disturbances so far exceeds all others that the medical profession should take greater cognizance of the disorder and bend all efforts toward lowering the rate. There is no question but the problem is a great one, but there is also considerable doubt as to whether or not all death certificates giving the cause as heart disease are honestly, or, I might say, intelligently, filled out. Increase in the registration area gives a large list of cases that have never been accurately worked out, and the law compels the physician to make some diagnosis. When death does not occur until the heart action stops it is all too easy to say "Chronic Myocarditis", when the real causes are obscure. Again, some of our surgical colleagues seem reticent to admit that in many instances death may be the result of any surgical procedure, and the responsibility is placed upon the heart.

Reviewing statistics, while tiresome, is the only concrete evidence that can be produced to properly convey the seriousness of the problem confronting us; in 1924, 176,871 died from heart disease, while in 1925, 191,226. Beginning in 1911, and including 1925, the following is the ratio per 100,000:

1911 — 141.1	1919 — 131.0
1912 — 142.8	1920 — 141.9
1913 — 138.9	1921 — 140.9
1914 — 142.2	1922 — 148.4
1915 — 147.6	1923 — 157.3
1916 — 150.6	1924 — 178.4
1917 — 153.8	1925 — 185.5
1918 — 153.3	

Roughly, approximately two per cent of the population are suffering from definite organic heart disease. Taking these figures and the population of the country as 100,000,000, it will be seen that the expectancy of life from heart disease is about ten years. Therefore, such an organization as the Association for the Prevention and Relief of Heart Disease, which was started shortly before the World War, is most

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necessary and should have the cooperation of every physician, so that benefit may be afforded those suffering from cardiac disorders, and the study of prevention may be encouraged.

Dr. Haven Emerson, in the analysis of 927 cases, showed the following etiologic distribution:

Acute rheumatic fever	331 or 35.8%
Acute tonsillitis	207 or 22.3%
Syphilis	122 or 13.1%
Scarlet fever	78 or 8.4%
Diphtheria	47 or 5.07%
Pertussis	14 or 1.5%
Measles	54 or 5.8%
Carious teeth	63 or 6.8%
Chorea	11 or 1.1%

Here nearly two-thirds of the cases show a rheumatic infection or a focus of infection which, to our best knowledge, is the forerunner of acute rheumatic fever. These figures indicate, in my estimation, very nearly the correct etiology of heart disease. While many cases of clinical chronic myocarditis show no pathological lesion at autopsy, as shown by Cabot, it is not unreasonable to surmise that rheumatic infections may weaken the neuro-muscular conduction without showing evidences of inflammation or degeneration. My personal opinion is that the figures in the future, showing the etiology of cardiac disease, will show even a still greater preponderance toward the rheumatic infections.

With this in mind, it is quite evident that the treatment of heart disease resolves itself immediately into one of prevention. The quack, charlatan, would be medical cults. Christian Scientists, etc., are exerting such a great influence on the public that when these pseudo scientists advise against the removal of foci of infection in children, the fond mother is all too willing a listener; also, the laryngologist is inclined to be too conservative, and many infected tonsils are allowed to remain. Any tonsil that remains inflamed, or around which is constantly a low grade inflammatory area, should be removed, whether or not pus can be squeezed from the crypts. Sinuses have not received proper attention, and the teeth of children have been neglected. It is these foci occurring before the age of puberty that must be eradicated at the first sign of trouble if heart disease is to be prevented later. Now that prevention of some of the acute infectious diseases is possible, it is not at all unlikely that many of the organisms belonging to the rheumatic infection group will become even more predominant. When the adult age is reached, there are other sources of infection which must be added to the foregoing, such as the appendix, gall-bladder, sluggish bowels, especially associated with hemorrhoids, torn cervices, ingrowing toe nails, urinary tract, prostate gland, etc. It is not only necessary to rule each and every one out as a cause, but it is imperative to remove, if possible, each one around which there is a shadow of a doubt as to whether or not it is one of the causes of a beginning cardiac disorder. Heart disease should have no conservative or palliative treatment in its incipiency.

The failing heart, regardless of its cause, is the condition that the general practitioner is most frequently called upon to treat. Patients with failing hearts should be put immediately to rest. Rest not only in regard to physical activity, but also to mental uneasiness, for, above all, it must be a comfortable rest. Practically all of these people are restless in the supine position. Many have arrived at the conclusion that lying in bed increases their discomfort, and that they are easier in an upright position. However, they should be put to bed with some sort of bed-rest, arranged in such a manner that they are comfortable; the degree of inclination can be measured only in regard to the ease of the individual. In some cases it is necessary to provide a stand or table in front so that a forward leaning position may be obtained. The bed itself should be a narrow one, with springs and mattresses that do not sag. The restlessness due to the anxiety of the mind and to labored breathing must be relieved at once by some form of sedative. The milder the drug the better it is for the patient, but omission of this will delay the response to treatment, if not be a source of fatal termination. Bromides and chloral afford the best and easiest relief in the majority of cases, but many will need, for a few days at least, small doses of codeine or morphine. Other drugs that may be tried are barbital, luminal, sulphonal, trional, etc. Rest is the first and most important phase of the treatment of heart disease, although many physicians do not realize its importance.

Digitalis, or fox glove, is the principal drug used in failing hearts. Its action is really one of rest, which is produced by lessening the conduction in the bundle of His through stimulation

of the vagus and direct action on the bundle. Whether or not the contractile power of the ventricular fibres is increased is a debatable question. The form in which digitalis is used makes but little difference. Personally, I feel that the simpler the preparation the better it is for the patient, especially economically, and confine my use to the powdered leaves and to the tincture: also, mouth administration is the method of choice, although, in cases of special emergency, some forms may be given intravenously. In regard to dosage, there are two schools, those who believe in the large doses and rapid digitalization, and those who favor the small dose. The amount of the large dose is figured by the Eggleston Method:

$$\frac{\text{C. U.} \times 0.15 \times W}{1000} = \text{grams powdered leaf in total daily amount.}$$

$$\frac{\text{C. U.} \times 0.15 \times W}{100} = \text{cubic centimetres of the tincture in total daily amount.}$$

$$\frac{\text{C. U.}}{100} \times \text{wt.} = \text{cubic centimetres of infusion in total daily amount.}$$

The cat unit was figured by Hatcher as the weight of the dried drug, in milligrams, that is required to kill a cat, one kilogram in weight when solution is injected intravenously. For the average person (150 pounds) the preceding formulas work out to 2.25 grams (34 grains) of powdered leaf, 22.5 cubic centimetres (5½ drams) of the tincture, and 150 cubic centimetres (5 ounces) of the infusion. About one-half of the dose is given at first, followed in six hours by one-fourth, and in another six hours by one-eighth to one-sixth. After this, about one-tenth is given every six hours. My own method is to give one and one-half drams of the tincture every four hours for four doses for three days, then cut in half for three days, and then one-half again for usage until thoroughly digitalized. The large dose method must not be used in patients having had digitalis within ten days. The small dose method gives one-eight to one-fourth gram (II gr.-IV gr.) of the powdered leaf or 1.25-2.5 cubic centimetres (MXX-MXL) of the tincture every four hours for four doses a day until digitalized. Objection to this method is that, first, the small doses seem more inclined to produce vomiting before complete digitalization, and, second, in case the drug is not up to standard, the length of time required to get the desired action is too long.

In cases of emergency, digitalis may be given intramuscularly or intravenously. Intramuscular injection may prove very irritating by producing a local reaction in the tissue. One to two cubic centimetres of the tincture, well diluted, may be given safely intravenously.

Continuation of the drug after the patient has become active is necessary in many cases, from the economic standpoint. Large doses should never be used; in fact, rapid digitalization should never be done in ambulatory cases. The dosage for people required to be at work should be just large enough to keep the pulse rate between seventy-five and eighty a minute.

Other drugs that are used which have action similar to digitalis are ouabain, squills, apocynum, hellebore, strophanthus and convallarin. Their use is not advised, although some advocate them. Strophanthus is probably the most recognized of the group and is given in following dosages: Tincture of strophanthus, eight to ten minims, and crystallin strophanthin, 1/150 gr., intravenously. It is used for intravenous therapy and in those cases in which digitalis produces toxic effects.

There are a number of drugs that are used in emergencies. While, scientifically, they have no action on the heart muscle, still they have their advocates and when one sees results following their administration there is considerable hesitancy in following the advice of those working in the laboratories, especially when there is no harm that can be done. Among the most commonly used are camphor, caffeine, theobromine, strychnine, adrenalin, ammonia, alcohol and the nitrites. Caffeine does slow the heart at times and its diuretic action is valuable. It is given in two to five grain doses intramuscularly. Theobromine is a diuretic and is given in five to fifteen grain doses over a limited period of time. Strychnine acts on the nervous system and probably owes its value to the fact that it tones up the body generally. Adrenalin produces vaso-constriction, but has no direct action on heart muscle; ammonia and alcohol at least produce a feeling of warmth and well-being which helps to relieve the apprehensiveness of the patient. The nitrites have no use except in angina. Camphor seemingly stimulates the heart. Whether this has any scientific basis or

not, I have seen rapidly failing hearts show improvement after its administration.

The diet should be varied to meet the individual case. There is no general rule that can be laid down. In many cases the Karell diet which consists of four glasses of milk or about eight hundred cubic centimetres in twenty-four hours is preferable. In others, dry food seems to be the best. In obese patients it is the lack of diet that is the most essential. If the patient is given a light, nutritious diet, sufficient to preserve bodily strength while at rest and which contains no irritating or indigestible foods, the situation in most cases has been met. In certain hypertensive heart disturbances and nephritis the reduction of salt intake may be recommended and in cases where there is pronounced edema the curtailing of fluid may be advisable. Bowel activity should be sufficient to carry off any excess fluid and still not active enough to interfere with the comfort and rest of the patient.

Therapeutic baths have no special effect on heart muscle but will, when given below body temperature, produce vaso-constriction, thus causing a secondary slowing action of the heart.

Having taken care of the failing muscle, attention must be then given to the etiological factor that produced the failure. As previously stated, if rheumatic in origin, foci of infection must be eradicated. Syphilitic heart disease should be treated intensively with anti-syphilitic measures. Arsenicals, such as arsphenamine, neo-arsphenamine, and sulph-arsphenamine are indicated, but their action should be watched carefully for at times they have a deleterious action on the vascular system. Mercury given preferably by inunction and bismuth intramuscularly should be used. Potassium iodide by mouth is best administered in moderate doses, twenty to sixty grains a day. The treatment of hypertensive heart disease is based indirectly on the cause of the hypertension, which in many cases is obscure. Proper elimination, reduction of salt intake, dietary treatment of nephritis and diabetes, if either is present, is indicated. The use of nitrites is most discouraging and administration of hepatic extract has not proven beneficial except temporarily. Lately I have been giving small doses of calcium iodide and benzyl benzoate, with some result, which is probably due to instructions to the patient as to the mode of living. Diphtheritic heart disease must be prevented by the early use of anti-toxin. Valvular heart disease is of importance only as valve changes produce an extra burden on the heart muscle and increases its work. No medication can improve a damaged heart valve.

The future course of a patient recovering from an attack of decompensation should be clearly outlined, especially as to exercise. The heart muscle, like skeletal muscle, must have a certain amount of work to keep up its general tone, but this amount varies with each individual case; when any exercise produces a feeling of beginning exhaustion or dyspnœa, too much has been undertaken. No exercise that is sudden, violent or competitive should be attempted.

Acute or subacute endocarditis is practically always the result of a rheumatic infection. Vaccines and serums have been tried with varying successes and it may be that Prof. Small's new organism will give us a specific for the disease. Salicylates have been of no value. Neutral acriflavine, mercurochrome and gentian violet intravenously have been used recently, and while there seems to be some justification for their trial, still they have not been sufficiently used to be able to publish enough statistics as to their value. Cacodylate of sodium intravenously has up to the present time given the best results. Transfusions aid only as the general condition of the patient is improved, especially as there is usually present an anemia.

Pericarditis is usually preceded by an attack of rheumatic fever and the treatment should be instituted along these lines. Salicylates in large doses will help in a limited number of cases. An ice bag to the præcordia is of more value than any remedy, especially so when pain is present. If the heart muscle shows signs of weakening, digitalis should be administered. In those cases in which there is a large amount of fluid that persists and embarrasses the heart, parancentesis should be done. The amount of fluid to be withdrawn varies with the character of the fluid and the size of the effusion. In cases where there is only a moderate amount, a syringe full withdrawn may stimulate the absorption of the rest. There are several sites suitable for the operation and the choice lies with the operator; the two used most generally are, first, a point midway between the maximum apex beat and the left border of the cardiac dullness in the fifth interspace; if the apex beat can not be determined, measure in about an inch from the left border; second, the angle formed by the ensi-

form cartilage and the left costal margin. In adhesive pericarditis it has been found that portions of the ribs, usually the third, fourth or fifth, may be removed when the adhesions are producing retraction of the chest wall. Diuretics, cathartics and diaphoretics tend only to weaken an already weakened heart muscle.

The treatment of angina pectoris is divided into two phases. During the attack the use of nitrites is indicated: either the inhalation from amyl nitrite pearls or the administration of nitroglycerine, in 1/100 grain doses. During severe attacks the use of morphine is strongly recommended. In the interval the patient must avoid those things that are liable to provoke an attack: also, search should be made for an etiological factor. Exertion, constipation, worry, excitement, gastric distress, irregular living, excesses in food, drink and tobacco should all be avoided. A search should be made for foci of infection and anti-syphilitic treatment is often beneficial. Surgical treatment is in the trial stage.

As the diagnosis of the different arrhythmias depends largely on some of the instruments of precision, it is useless here to go into detail as to their treatment. Paroxysmal tachycardia may be aborted at times by stimulation of the vagus, either through direct pressure at the level of the cricoid cartilage or by pressure on the eyeball. Ice bag to the præcordia often stops the attack, or the drinking of ice water. Digitalis is used in some cases. Auricular flutter and fibrillation are indicative of the use of digitalis to the point of heart block. Quinindine has been used successfully in fibrillation, but there is a question whether or not it is more efficacious than digitalis. Treatment of heart block is very unsatisfactory. Search for the underlying causes, such as syphilis or arterio-sclerosis, must be made. Drug therapy is very discouraging and no one drug will do for all cases; among those to be tried are atropin, adrenalin, ammonia, nitrites, camphor and caffeine. Pulsus alternans is indicative of myocardial weakening and should be treated as such.

Briefly, in conclusion, allow me to urge upon you that the eradication of heart disease lies not in the curing of the disease but in the recognition and prevention of the causes; the greater percentage of which are of rheumatic origin.

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Joint discussion opened by

Dr. T. Z. Cason, Jacksonville:

Just a few points with reference to Dr. Caldwell's paper: I have used the apparatus referred to for about eighteen months. The first point I want to make is that if any of you contemplate the use of this spirometer, you will probably find true some of the things Dr. Caldwell has said. But in the first place, it is going to take you months before you reach the point where it will mean anything to you, even though you use it frequently. The variations are numerous and in spite of the fact of the claims of the manufacturer and those who have used it, it does not always pan out just as you would expect. That is the first point.

The next one is that while it is of considerable value and should be used if you are doing much heart work, I believe its greatest value is in the sick room and the hospital and in cases where the patient is unable to take any exercise whatever. It is a safe apparatus. The experiment or test may be made without any danger to the patient and for the really sick person, in the hospital, for instance, it will give real benefit, but, as I stated, before you get any real benefit whatever, it will have to be used over a considerable period of time.

Dr. Julian E. Gammon, Jacksonville:

I should like to say a word about heart reserve since I have been interested in the subject and read a paper on heart reserve before the last meeting. I tried to demonstrate that heart reserve could not be estimated mechanically in normal or pathological hearts. In pathological hearts you may have evidence of disease handicapping the heart, but the degree of handicap of the heart reserve can best be determined by observing the heart perform within the patient's sphere of activity, and the patient's ability to increase

his heart reserve by retraining without symptoms of heart failure. The pulse rate and blood pressure readings are too variable and greatly influenced by emotion to be of any value in determining the heart reserve and there is no mechanical apparatus which has been devised as yet that will give us this information. I am afraid clinical medicine is not receiving the attention it should, and that there is a tendency for laboratory and mechanical diagnosis to supplant clinical observations.

Dr. W. C. Blake, Tampa:

I should like to mention one point in connection with the paper of Dr. Meredith Mallory. He mentions in the treatment of cardiac edema, salt-free diet, limitation of fluids and the giving of an adequate amount of digitalis. These things, of course, are of prime importance. However, if in addition, ammonium chloride and novasural are given the edema may be mobilized in about one-half the time. Patients respond to this treatment usually even where other methods have failed. Ten grams of ammonium chloride is given daily and an ampoule of novasural intravenously every second to fourth day. The diuretic effect of novasural lasts from twenty-four to forty-eight hours or even longer, so that the interval between injections should be gauged by the duration of the effect. Nephritic edema also responds to this treatment and even with anasarca from biliary cirrhosis much of the fluid can be eliminated.

Dr. J. G. DuPuis, Miami:

I wish to emphasize one point Dr. Mallory brought out in his paper, and that is the point of the treatment of rest, not only with reference to this particular condition, but I would like to emphasize that in the many infectious and pathologic conditions with which we meet, particularly in heart conditions, there are more important things than mere rest in bed. You take the active business person, man or woman, tied up in business affairs, some conditions should be brought about to rest the mental condition of the patient who is overwrought and overanxious over many things, and if not lying in bed will probably aggravate the condition more than really give the patient rest. This is particularly true of this mechanical age. I think since the age of the automobile, we have an increased percentage of cardiovascular diseases. The automobile, although in all its realm of pleasure and usefulness, has brought about great conveniences, at the same time it has brought about the rapid development of more cases of cardiac disease. Therefore, gentlemen, I particularly wish to stress on this occasion and emphasize the treatment Dr. Mallory has suggested in his paper, of rest.

CONCLUSION

Dr. Herbert Caldwell, Lake City:

I sent Dr. Erwin of Jacksonville a copy of my paper and received from him this letter in which he says:

"I quite agree with your conclusions. The paper covers the situation thoroughly."

Also in a letter received from Dr. Paul White, of Boston, he says:

"The spirometer is also of little value except in well marked heart failure. It is of no value in differentiating slight heart disease from other conditions."

Like Dr. Cason, I had hoped when I started to work with the spirometer that it would be an instrument I could take to the bedside and tell whether that patient had sufficient cardiac reserve to go through some anticipated strain. So far I have not found the results would justify relying on this instrument.

With Dr. Gammon, I agree that if you can estimate what the patient can do without signs of distress, that is probably the best way to estimate cardiac reserve.

CONCLUSION

Dr. Meredith Mallory, Orlando:

I thank Dr. Blake for bringing out the use of novasural, with which I have had very little experience.

On the subject of rest, I would like to add that be sure you do not make a neurotic out of your patient by giving him too much rest.

CONGENITAL HYPERTROPHIC PYLORIC STENOSIS*

EDWARD JELKS, M.D., F.A.C.S.,
Jacksonville.

When vomiting, visible peristalsis, abdominal tumor, and constipation occur in the adult one hardly doubts that the patient has a mechanical obstruction of the bowel. When these conditions are noted in the infant, however, we are prone to consider the presence of a mechanical obstruction only after dismissing from our minds the

*Read before the Riverside Hospital Staff February 21, 1927.

other less likely possibilities. In the adult, we do not hesitate to make a diagnosis of obstruction even though a tumor may not be palpated. Surely, it must be that signs as fundamental as vomiting, visible peristalsis, and stoppage of the bowels indicate similar pathological processes regardless of the age of the individual. The same careful history and physical examination of the infant that one makes of the adult would indicate pathology which is recognized readily in the grown-up.

With these facts in mind let us discuss a type of actual obstruction in infants, namely, congenital hypertrophic pyloric stenosis. Its pathology is a localized hypertrophy of the muscles of the stomach wall in the pylorus. The muscles chiefly involved are the circular ones. At operation there is seen a firm constricting section of tissue almost cartilaginous in hardness. On section this is found to involve a small part of the terminal stomach wall and to extend down through the pyloric ring, protruding into the duodenum very much in the shape of the uterine cervix. It is important to bear in mind this last point, since in cutting through the hypertrophied tissue at operation it is easy to niche the part of the duodenum which lies over the lower end of the tumor. I did this once without any serious results, but there are reports of peritonitis resulting from such an accident.

Etiologically the condition possibly results from an improper functioning of the autonomic nervous system which causes a permanent spasm of the muscles of the pyloric stomach wall. There is a theory, however, that it is a hypertrophy of hyperfunction.

May I recall the following case to illustrate the usual clinical story and some points in the handling of this condition:

About one year ago Baby D., male, came under our care because of vomiting, loss of weight and constipation. At birth, four months previously, he appeared normal in every way. He weighed seven and one-half pounds. At the age of four weeks he began to vomit at irregular intervals. After one week, vomiting occurred following each nursing and became explosive in character. The child had been taking regular three-hour feedings of breast milk only. The mother said that at this time "she did not see waves in the stomach, but did see two lumps in the stomach which did not move but would come and go." Four days of treatment with thick food and atropine gave some relief from the vomiting, but since this onset of the severe type at the age of five weeks, the vomiting has never stopped completely. The longest period of its cessation has been five days. Two times in the past five weeks there have been so-called "spells of vomiting", at which time the bowels did not move even with enemata. At the beginning of the present attack, four days ago, Dr. Shaw, after a barium meal gastro-intestinal study, reported a normal patulous pylorus with a normal stomach, duodenum and small bowel. Nevertheless, the patient continued to vomit milk and water, to lose weight, and the bowels did not move for the four days between this X-ray examination and his admission to the hospital.

On examination, the baby appeared in a languid stuporous state. His temperature was 102 degrees per rectum, and pulse weak and rapid. He was decidedly emaciated, with dry, loose skin. His weight was eight and one-half pounds. The abdomen was distended, especially above the umbilicus. Beginning along the costal border, there could be seen, especially after taking food, a deep peristaltic wave pass across the epigastrium and disappear just to the right of the midline. Sometimes it remained still, giving the appearance of two lumps, which the mother had described. On the first examination it was not possible to make out a tumor. Later, however, a hard, movable tumor could be felt in the right epigastrium about three-fourths of an inch in diameter. This was especially apparent when the patient was given liquids. On account of the age of the patient, four months; the rather late onset of vomiting at four weeks of age; and X-ray findings which indicate the absence of a mechanical obstruction, we might have had difficulty in arriving at a definite diagnosis had we not relied upon the fact vomiting, visible peristalsis, constipation and tumor mean obstruction. Because of the patient's high temperature and poor physical condition, we gave salt solution hypodermically. Atropine was given empirically. The following morning his temperature was normal, but the vomiting continued. On the fourth day after admission, we operated and found the typical picture of congenital hypertrophic stenosis. The technique followed was that of Fredet-Remstedt. When the hypertrophied area was incised, the mucous membrane straightway unfolded, making a normal size lumen. A tag of omentum was attached over

the gapping opening through the stomach wall. The patient was given liquids in small quantities beginning two hours after the operation. His convalescence was steady and uneventful. There has been no vomiting since the day of the operation.

Besides demonstrating the cardinal characteristics of congenital pyloric stenosis, this case brings up three points which I wish to consider in more detail:

1. The first is the question of therapy. Many pediatricians insist that this trouble can be cured medically. There are just as ardent exponents for surgical treatment in all but the mild cases. It is not my desire, nor have I the experience to try, to settle this question. The first thing to do is to recognize the presence of the stenosis. In our case, medical treatment, consisting of diet and atropine given over long periods, had not given relief.

2. The second point which impresses us is the finding of an exception to the rule that unqualified reliance can be put upon X-ray studies in making a diagnosis. Almost everyone agrees that in true stenosis there is unmistakable, though not necessarily complete, retention in the stomach of at least fifty per cent or more of the barium meal at the end of four hours. The contrary was true in this case. The barium passed through the stomach. Still the patient continued to vomit, although physiologic doses of atropine were given.

3. The third and most important point this case brings out is the value of pre-operative care. These babies, by the time they reach the hands of the surgeon, are usually very toxic. The prolonged vomiting and lack of nourishment have resulted in thorough dessication of the tissues with chemical changes of acidosis. They are extremely weak. There are practically always present one or more degrees of fever. We had one case with temperature 104.5 degrees upon admission. Under the administration of fluids, glucose and alkalies hypodermically or intravenously, the chemical picture changed completely and the temperature returned to normal. Since there is no need for undue haste, everything should be done to strengthen the patient before operation. It is the lack of this careful preparation that constitutes one of the chief elements in surgical mortality.

Our interest in congenital hypertrophic pyloric stenosis was aroused acutely last year by the unusual occurrence to us of two patients being admitted to the hospital on successive days with this condition. About six weeks later we had another admission. The three were operated upon with complete recovery.

Dr. Stewart G. Thompson, of the State Board of Health, has favored us with some interesting figures. During 1925 there were in Florida 29,301 births. Of this number, 634 died between the ages of two weeks and five months. Six had the diagnosis of congenital hypertrophic stenosis; 66 died with such indefinite diagnosis as gastro-intestinal disease, stomach trouble, convulsions, malnutrition, etc. With a medical and surgical mortality of ten per cent in cases of possible congenital pyloric stenosis, which is two to four times as much as it should be in the average handling of cases, there probably were one or two hundred cases of this condition in our State last year. Or, interpreted another way, our mortality must be much greater than the average.

It is to be hoped that we physicians in Florida are not overlooking this intensely interesting and serious condition. Scott gives, in the Medical Journal and Record, 1925, two helpful rules in caring for sick infants.

He writes: "First, do not wean the baby because it is vomiting its mother's milk, but strip it and examine the abdomen. Palpate for a tumor at the pyloris." Secondly, "do not physic the patient for constipation, especially when vomiting, until you have examined the naked abdomen."

May I not add: In the presence of vomiting, visible peristalsis and constipation in infants, think first of obstruction of the intestinal tract.

IMPORTANT

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DR. JOSEPH YATES PORTER

Doctor Joseph Yates Porter was born in Key West, Florida, October twenty-first, 1847, son of Joseph Yates Porter and Mary A. (Randolph) Porter. Doctor Porter obtained his preliminary education in the schools of Burlington, N. J., and then entered Jefferson Medical College in Philadelphia, from which he graduated in 1870. During the same year he was appointed Acting Assistant Surgeon in the United States Army and sent to Fort Jefferson, where he spent three and a half years and passed through an epidemic of yellow fever. He had yellow fever himself in 1867 and won a great reputation in the treatment of several later epidemics. In 1875 he was appointed Assistant Surgeon in the army and five years later was promoted to the rank of Captain. He remained in the army for nineteen years, until 1889, serving at Tortugas, Key West, Tampa, Miami, and in Texas. In 1887 he was in charge of the yellow fever epidemic as Chairman of the Monroe County Board of Health at Key West and in control of Government relief at Tampa.

Upon his retirement from the army in 1889 he was made State Health Officer of Florida, serving in that capacity for twenty-eight years, to 1917. He probably had more experience in the management of yellow fever epidemics than any other man of his day, and was recognized as an expert diagnostician in that disease. Due mainly to preventive measures inaugurated and carried out by him yellow fever was banished from Florida, so that people seek our State because of its freedom from disease rather than shun us because of recurrent yellow fever epidemics.

Doctor Porter was a member of the American Medical, Southern Medical, Pan-American and Florida Medical Associations—an ex-president of the latter; a member of the American Public Health Association, Monroe County Medical Society, and Association of Military Surgeons of the United States, and many other scientific health associations.

He took an active part in all movements relating to the health of our people and was an ardent advocate of organized medicine, although his participation in public welfare work prevented him from devoting any time to active practice.

In 1900 he was elected a representative from Monroe County and served his term in the Florida Legislature.

Doctor Porter was married in 1870 to Louisa Curry, who, with three children, William Randolph Porter, Mrs. Mary Louise Harris and Dr. Joseph Yates Porter, Jr., survive him. Doctor Porter died on March 16, 1927. He will be remembered as the State's greatest sanitarian.

Most men after reaching the age of seventy rest on their oars, but Doctor Porter's active service almost to the day of his death was remarked by all who knew him. He served during his late years as City Health Officer, District Health Officer, and President of the Chamber of Commerce of his native city without remuneration. The probability that he would soon reach the point where active participation in civic affairs must cease gave him much concern and distress.

Doctor Porter desired to serve his fellow men to the last day of his existence, and no greater tribute can be paid to the memory of any man than to say: "He lived to serve mankind."

WM. R. WARREN, M.D., Key West,
Necrologist.

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JOSEPH YATES PORTER

In the passing of Dr. Joseph Yates Porter, Florida suffers an irreparable loss. Dr. Porter was born in Key West, October 21, 1847. He graduated from the Jefferson Medical College in 1870, and during the same year was appointed acting assistant surgeon of the United States Public Health Service, in which capacity he served three and one-half years, being stationed at Fort Jefferson, Dry Tortugas Island, off the coast of Florida.

In 1875 he entered the United States Army and served a number of years on the Mexican border, where he was associated with Dr. William Crawford Gorgas. During the epidemic of yellow fever in 1887 and 1888, he rendered invaluable service, having charge of the Government relief measures. His service during this time was accorded national recognition.

In 1889, when the State Board of Health was created by the Florida Legislature, Dr. Porter assumed the position of state health officer and secretary of the Board. In this capacity he served uninterruptedly, with efficiency and merit, until 1917, a period of twenty-eight years. Throughout this period, Florida was the prey of numerous epidemics, and Dr. Porter proved his outstanding worth as an epidemiologist and sanitarian. He was an authority on sanitation and epidemic diseases and was among the first to accept the mosquito theory of the transmission of yellow fever. He was a pioneer in preventive medicine, and his merited achievements, rendering living conditions better in the state, is now history. As long as there is a Florida, his memory will be cherished.

MEDICAL EXAMINERS GET RESULTS

The excellent work of the Florida Board of Medical Examiners in apprehending and prosecuting "diploma mill" operators is to be commended most heartily by the Journal. During the past year, the fruits of their efforts have been realized. National recognition of their work has been acknowledged in many ways. It is particularly interesting to note that in the March issue of the Federation Bulletin, published by the Federation of State Medical Boards of the United States, the following brief of their work is recorded:

"Almost ten years of effort of the old 'regular' board and the present composite board of medical examiners to eliminate illegal and fraudulent practitioners of medicine, have resulted in the arrest and indictment of a number of persons who will be tried in Tampa during the term of court which starts March 14. The voluminous data which the boards collected were laid before a federal grand jury; indictments were returned in some cases on charges of using the mails to defraud, or of having practiced medicine with diplomas and licenses obtained illegally, or of having illegally issued diplomas and licenses.

"The secretary of the present board of examiners, Dr. William M. Rowlett, believes that this investigation will prove to be more startling than the Connecticut diploma mill investigation, and that it may reach all sections of the country. A batch of licenses for the old Florida Eclectic Board of Medical Examiners was made by a lithographing house in Birmingham, Ala., in 1919, of which some officers of the board at that time have denied knowledge. The old 'regular' board of examiners went out of existence in 1920, yet a Birmingham printing house ordered fifty copies of licenses of this board from a Jacksonville company in 1922, and the order was delivered. The Tampa Tribune stated that, in many towns in Florida, 'doctors' without medical training, licensed through fraud and trickery, were ministering to the sick. It is this situation which the present State Board hopes will be cleared up by this investigation. Among those who have been indicted, or are being sought by federal authorities, are said to be:

Dr. George A. Munch, Tampa, formerly secretary of the old board of eclectic medical examiners.

"Dr." Charles C. Faiman, formerly of Chicago.

John J. Heitz, Orlando.

Paul C. Ronning, Lake Worth.

William H. H. Sharpe, St. Petersburg.

Joseph M. deGaetani, formerly of Jacksonville.

Lloyd B. Riley, St. Petersburg.

Dr. Samuel McCubbin, Kansas City, Mo.

"Dr." Benedict Lust, New York, naturopath and publisher of Nature's Path.

William A. Lucia, Brooklyn.

Francisco P. Trapani, New York City.

Francis T. Shyne, Washington, D. C.

Charles Wade Page, Chipley.

Edward J. Roach, formerly of Ormond.

Henry D. Sbordi, St. Petersburg."

WORKMEN'S COMPENSATION BILL

It is understood that there probably will be introduced during the present session of the Legislature a workmen's compensation bill. In some states, where laws have been enacted, the medical profession has not been awake to the importance of the medical phases of the law. After these laws are made, it is almost impossible to procure any change. The members of the medical profession of our state should be on the alert if such a bill is introduced and analyze carefully the workings of the bill. In a communication from Dr. Wm. C. Woodward, executive secre-

tary of the Bureau of Legal Medicine and Legislation of the American Medical Association, he makes the following statement:

"The underlying principle of all such legislation is that injuries to workmen are necessarily incident to the industry; that workmen should not lose by reason of such injuries, but that the costs should be borne by the industry itself in the first instance and then passed along to the consuming public as a part of the cost of the product. The public that buys the goods pays the manufacturer a price that enables him to reimburse the workman for the loss sustained by reason of the injury.

"That principle is probably perfectly sound. Unfortunately, however, the proponents of such legislation generally seek to compel the medical profession to bear a large part of the cost of the injuries by putting the profession in a position where it is supposedly required to render service to injured workmen at prices far below those charged to the community generally. This, of course, should not be.

"Another important matter to be considered is whether the employer or the employee shall have the right to choose the physician in any particular case. There is a strong tendency on the part of employing interests to demand the right to impose on the injured employee physicians of the employers' choice. The working man is put in the position of an infant, incapable of determining what is and what is not good for him, when it comes to medical treatment."

ON THE RELATION OF THE FUNCTIONS OF THE GLANDS OF INTERNAL SECRETION TO THE THINKING, THE FEELING, AND THE STRIVING OF MAN.

(*Continued from page 260*)

establish any correlation between special types of physical structure and special mental reaction types in your own patients. It is not uninteresting, too, aside from medical practice, to test out these new conceptions with regard to persons whom one knows familiarly, observing in how far temperamental and characterological features are, in reality, correlated with the types of physical structure to which they have in these newer studies been attributed.

In conclusion, I shall throw upon the screen a series of lantern slides illustrative of some of the principle endocrine syndromes on the one hand and of some of the principle psychiatric syndromes on the other. I shall also show a few slides illustrative of the main types of physical constitution. If my paper and these lantern slides shall have increased your interest in the subjects dealt with I shall be very glad.

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STATE NEWS ITEMS

Though the Fifty-Fourth Annual Convention of the Florida State Medical Association at West Palm Beach has passed into history, echoes of its success and of the delightful entertainments planned by the Palm Beach Medical Society and their wives are still being heard throughout the state. For, despite the depression caused by bank failures and the bursting of the real estate boom, West Palm Beach provided for the visiting physicians, their wives, mothers and daughters a three-day program of entertainment conceded one of the finest in the history of the state conventions. No effort was spared to give the visitors as much as possible of the vividly delightful winter life that has made the Palm Beaches renowned among the playgrounds of two continents.

Outstanding among the events planned for the feminine visitors was the luncheon at the Breakers, Palm Beach's new $7,000,000 hotel, opened last Christmas. With several hundred guests in their loveliest frocks and hats, the great dining room of the Breakers, with its vistas of sapphire ocean from every window, was like nothing so much as a huge flower garden, and with a talk from Dr. H. Mason Smith, retiring president, as the principal feature, the program was keenly interesting.

The yacht trip arranged for Monday afternoon, while less elaborate, was another big success, and the final event of the colorful program was the banquet and dance given on the roof garden of the New Palm Beach hotel Tuesday night. More than five hundred doctors and their wives gathered in the exotically beautiful surroundings of the roof garden, and the event—the courtesy of the Wampole Company, of New York—set new standards of brilliance for convention entertainments.

Then, Wednesday morning—a delightful close to a perfect program—there was surf bathing in the blue waters of the Atlantic.

To Mrs. George M. Dawson, as chairman of the woman's committee, must go first credit for the perfect success of the entertainment planned for the doctors' wives, and the smoothness with which it was carried out.

A pamphlet entitled "Preliminary Report of the Commission on Medical Education" has recently been prepared and can be obtained, free of charge, by writing the Commission on Medical Education, 215 Whitney Ave., New Haven, Connecticut.

The newly appointed officers of the Florida Railway Surgeons' Association are as follows: Dr. J. S. Turberville, Century, president; Dr. C. W. Shackelford, West Palm Beach, vice-president; Dr. E. W. Warren, Palatka, sceretary-treasurer.

The regular meeting of the Suwannee River Medical Society, composed of Columbia, Hamilton, Madison and Suwannee Country Medical Societies, was held in Lake City on April 8th. The attendance was excellent. Dr. Eustace Long, Madison, president of the society, and Dr. J. D. Gable, Lake City, neuro-psychiatrist at the government hospital, read excellent papers. Dr. H. C. Von Dahm, medical officer in charge of the government hospital in Lake City, invited the society to meet with his staff at their next meeting.

On May 2nd, Dr. J. N. Fogarty tendered his resignation as mayor-commissioner of the city of St. Augustine.

At the meeting of the Pinellas County Medical Society, held Friday, April 22nd, at the Florida Art School, St. Petersburg, the following papers were read:

"Arteriosclerosis"—Dr. H. L. Putnam. Discussed by Dr. W. C. McConnell.

"Early Treatment of Acute Otitis Media and Mastoiditis"—Dr. M. H. Stuart. Discussed by Dr. N. W. Gable.

The Southern Pediatric Seminar has received a grant from the Commonwealth Fund for the purpose of giving scholarships to doctors in the various parts of the South. This scholarship will include $25.00 for tuition and $30.00 for board. These scholarships will be granted to men in towns or communities of 1,000 inhabitants or under. It is their desire to encourage men who have been out of college for a number of years and who have not taken postgraduate work to come for this course. All members of the Association desiring this scholarship are requested to forward their names without delay to the chairman of the Executive Committee of the Florida Medical Association, Dr. R. H. Mc-

Ginnis, 1463 Oak St., Jacksonville, in order that selections may be made for representatives from our Association.

Dr. B. S. Stutts, formerly of Munson, has recently moved to Dunnellon, where, in addition to his practice, he will act as surgeon for the Atlantic Coast Line Railway Company.

In the advertisement of the Victor X-ray Corporation, page vii, March issue, the insert "Atlanta: 155 Forrest Ave., N. E." should have appeared. This notation of their territorial branch was unintentionally omitted.

Dr. J. N. Fogarty, of St. Augustine, resigned as chief surgeon of the Florida East Coast Railway, effective May 15th. This information came as a surprise to Dr. Fogarty's many friends.

For the wives of the physicians the Palm Beach convention was of more than ordinary significance, since it marked the first annual meeting of the state auxiliary, organized during the fifty-third convention in Gainesville.

Postponing their meeting from Tuesday morning to Tuesday afternoon, in order that members might have the privilege of hearing the address of Dr. Lewellys F. Barker, of Baltimore, the auxiliary gathered in the spacious lounge of the Breakers immediately following the luncheon.

Mrs. Wilburn Lassiter, state president, outlining the work already accomplished during the first year of the auxiliary's existence, stated that organization already had been perfected in Lake, Sumter, Bradford, Pasco, Hernando and Citrus counties. Urging every member of the auxiliary to do her part, the president declared she wanted a one hundred per cent organization of all counties in the state when the association meets in Tampa next year.

Another speaker who added interest to the meeting was Mrs. C. W. Roberts, of Atlanta, president of the Woman's Auxiliary of the Georgia State Medical Society. Mrs. Roberts told of the work already accomplished by the auxiliary of her state, and her talk elicited keen interest among the members.

ROBERT LAFAYETTE HARRIS

Doctor Robert Lafayette Harris died at his home, 1727 Riverside Avenue, Jacksonville, April 27, 1927, of coronary thrombosis. His health had gradually declined for the past several years, but of late had been improved, so that the suddenness of his passing was a great shock to his friends and the community at large.

Dr. Harris was born in 1858, and graduated from the Medical College of Ohio, Cincinnati, in 1882. After taking extensive post-graduate courses, he located in Orlando, Florida, where he built up one of the largest surgical practices in the State and became the leading physician in his community. He operated very successfully a hospital in connection with his work. About 1909, desiring to enlarge the field of his activities, he moved to Jacksonville, where he purchased an interest in the former DeSoto Sanitarium. After several years of active work, his health beginning to fail somewhat and wishing to lighten his work, following an interest that was awakened by the earliest development of the X-ray, he took up this branch as a specialty. He became so proficient at this, as in other lines to which he had devoted himself, that he soon became a leader, and as such was recognized up to his death.

Dr. Harris held many positions of honor and trust during his lifetime. For several years he was a member of the original Board of Control of the Florida Farm Colony for Epileptics at Gainesville and rendered very valuable service in laying out plans for that institution. He was past president of the Orlando Medical Society.

Dr. Harris is survived by his widow, Mrs. Francis Harris, three sisters, Mrs. B. M. Nix and Miss Harriet Harris, both of Waycross, Ga., and Mrs. Mattie Caruth, Winder, Ga., four brothers, C. C. Harris, Clermont, Fla., Frank Harris, Statesboro, Ga., James Harris and Claborn Harris, of Commerce, Ga., and other relatives.

By all those who have known Dr. Harris he was loved and held in the greatest esteem. He was one of the oldest among us and his kindly good humor and pleasant personality made his friendship desired by everyone. The medical profession has suffered a definite break in its ranks which will be hard to fill.

H. D. VAN SCHAICK, M.D.,
Necrologist.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912.

Of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, published Monthly at Jacksonville, Florida, for April 1, 1927.

STATE OF FLORIDA, } ss.
COUNTY OF DUVAL. }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Shaler Richardson, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

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Editor	Shaler Richardson, M.D.	Box 135, Jacksonville, Fla.
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CONTENTS

PAGE

Surgical Treatment of the Bile Tract 278
E. Starr Judd, M.D., Rochester, Minnesota.

Deep-Roentgen Therapy 281
H. B. McEuen, M.D., Jacksonville.

The Rationale of Roentgen Ray Therapy in Dermatology 286
Elmo D. French, M.D., Miami.

PAGE

The Vomiting of Pregnancy 289
Homer L. Pearson, M.D., Miami.

Red Urine 291
J. A. Mease, Jr., M.D., Dunedin.

Kidney and Bladder Stone 292
G. F. Highsmith, M.D., Arcadia.

Editorial—The Woman's Auxiliary 295

State News Items 296

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SURGICAL TREATMENT OF THE BILE TRACT*

E. Starr Judd, M.D.,
Rochester, Minnesota.

Our conception of diseases of the gall-bladder and liver has been modified considerably by recent investigations on the physiology and function of these organs. It has been shown that the liver possesses great powers of recuperation, and following the removal of a portion of it, a rapid cellular hypertrophy takes place in the remaining portion. The removal of a large portion of the liver results in only a slight change in function, and, contrary to previous belief, an animal can survive complete removal of the liver for a short time. Mann has shown further that hepatectomized animals may become jaundiced, thus proving that bile pigment may form in other tissues than the liver. His experiments show that the reticulo-endothelial system of Aschoff is the most likely seat of the formation of bile pigments, the chief organs involved being the bone marrow, spleen, and liver. If a small portion of hepatic tissue is allowed to lie free in the abdominal cavity, the animal will die in a few days. At necropsy, it will be found that the fragment of liver has nearly disappeared and that the entire paritoneal surface is red and inflamed, the condition being similar to that seen in certain cases of pancreatitis. This may explain some types of shock following operations on the gall-bladder in which the liver has been unavoidably traumatized.

Several hypotheses have been advanced with regard to the possible function or functions of the gall-bladder, but none has been definitely accepted. It has been found that destruction of the organ or its removal has no untoward effect, and that a person may apparently live just as long and as comfortably without a gall-bladder as with one. When the gall-bladder is removed the intrahepatic and extrahepatic ducts become dilated and the sphincter activity at the ampulla ceases, so that bile flows more or less continuously into the duodenum. McIndoe and Counseller, using celloidin injections and corrosion, have been able to study the intrahepatic biliary and vascular trees, and have shown graphically various degrees of dilation of the intrahepatic ducts following removal of the gall-bladder as well as in partial and complete obstruction of the extrahepatic ducts. Their method is a modification of the one used by Hinman and Brown in studies on the kidney. Much investigative work has been carried out with a view to determining the significance of the changes in the intrahepatic ducts following cholecystectomy and to correlate them with the conditions found normally in animals without gall-bladders, but definite conclusions have not been reached. Animals without gall-bladders have large intrahepatic and extrahepatic ducts and no sphincter at the ampulla. Rous and McMaster have shown definitely that the gall-bladder concentrates the bile. It has been suggested that it may also act as a storage organ or tension bulb. Higgins has found in the rat, which has no gall-bladder, that a plexus of fine biliary channels is applied to the radicals of the portal vein. Since no such arrangement is found in the mouse, which has a gall-bladder, he thinks it possible that the plexus may be a mechanism analogous to the gall-bladder. Although nothing has been proved by this study, nevertheless, so far as I know, this is the first time that attention has been called to the existence of such a plexus, and it is hoped that further study may assist in solving the problem of function of the gall-bladder.

The etiology of disease of the gall-bladder is not known. It is natural to assume that the most common cause of cholecystitis is infection, and it is likely that infection does play an important part. However, in earlier reports of the bacteriologic study of disease of the gall-bladder, bacteria were found in a higher percentage than are found at present. It is possible that we are operating when there is less inflammation and more often in the quiescent interval than formerly, but it must also be admitted that in some of the cases in which the gall-bladder appears to be extensively diseased, no organisms are found in the tissues, bile, or stones.

A study of 100 cases of cholecystitis was made. After surgical removal of the gall-bladder it

*Read before the Duval County Medical Society, Jacksonville, Florida, March 1, 1927.

was placed in a sterile dish, covered with sterile gauze, and immediately taken to the laboratory for culture. In no instance was the specimen examined by the bacteriologist later than five minutes after its excision. Specimens from the wall of the gall-bladder, from the bile, and from the stones, when present, were examined in each case. Several mediums were inoculated in each instance and examined at stated intervals. In spite of the utmost care, contamination sometimes undoubtedly occurred. In most instances appendectomy had preceded cholecystectomy; thus soiling of the gall-bladder had sometimes occurred, and this probably accounts for much of the contamination, even though the specimens were washed one or more times in sterile solutions of sodium chloride. Culture of the tissue from the wall of the gall-bladder resulted positively in twenty-nine cases. This is subject to error, however, as three specimens showed two or more types of organisms. Only five of twenty-two specimens of "strawberry" gall-bladder gave positive cultures. In 7 per cent of the 100 cases the bile revealed bacteria; in three specimens streptococci were found, and in three a spore-bearing bacillus. Gall-stones were present in fifty of the 100 cases; in only five instances was it possible to obtain a positive culture from the stones, and one of these might have been due to contamination. *Bacillus typhi* and *Bacillus paratyphi* were not isolated, although in 21 per cent of the cases there was a history of typhoid fever. Mentzer has pointed out that thick, dark-green bile, as found at necropsy, is not necessarily indicative of infection of the gall-bladder. Several instances in this series support this contention. Thick, dark-colored bile was found in sixteen cases; six of these were cases of chronic cholecystitis, in four of which culture of the bile and of the wall of the gall-bladder was negative. Likewise in seven of eight cases of gall-stones, culture of the bile, of the wall of the gall-bladder, and of stones was negative. Also in one case of cholesterosis, in which thick, dark bile was found, no growth could be obtained from the bile or the contents of the gall-bladder.

In studying the effect of Dakin's solution administered intravenously, Mann found that the tissues of the gall-bladder were the first to be changed, and that definite non-bacterial cholecystitis was invariably produced. Soon after the solution was injected the gall-bladder became very red and tense, and there was an extravasation of blood from the capillaries into the tissues. Churchman and his associates (Research Laboratory of Bellevue Hospital, New York), on failing to find organisms in certain grossly inflamed gall-bladders removed at operation, concluded that the pathologic condition was due to changes in the blood vessels and causes other than bacterial invasion. Sweet and Mentzer believe that the presence of lipoid deposits in the gall-bladder, in association with the condition known as "strawberry" gall-bladder, is evidence that the gall-bladder plays a part in the metabolism of fat, and that these lipoids are not the result of infection. Although it is likely that several factors enter into the cause of cholecystitis, it is more evident now than formerly that some of these diseases occur independently of bacterial invasion. It is quite possible that in some instances the cause of the condition may be chemical alteration of the blood.

I believe that surgeons are called on to operate for cholecystitis or an allied condition more often than for any other abdominal disease. It is now recognized in a greater percentage of cases than formerly, and I believe it is more common than it was years ago. The clinical manifestations are usually definite, the principal symptoms being pain, usually severe, of sudden onset, and radiating characteristically to the back and shoulders. With this syndrome the trouble is almost sure to be due to disease of the gall-bladder, but an attempt to diagnose chronic cholecystitis in the absence of colicky pain is attended with much uncertainty. Soreness, tenderness, constant dull pain, dyspepsia, particularly evidenced by belching and flatus, and many remote symptoms may result from chronic inflammation of the gall-bladder. Since it has been shown many times that the infected gall-bladder may be a focus of systemic infection, resulting in rheumatism and cardiovascular disease, it is important to recognize chronic cholecystitis. Willius has shown that in 55 per cent of the cases of cardiovascular disease with which cholecystitis is associated, definite benefit and modification of the cardiac symptoms follow removal of the diseased gall-bladder. A surgeon is in an embarrassing position when he finds, on opening the abdomen, that the gall-bladder appears normal, although he had every reason to expect definite evidence of disease. In some instances this is undoubtedly the result of mistaken diagnosis; in others, however, unrec-

ognizable disease exists, which will be relieved by removal of the gall-bladder. The cause of the symptoms may possibly lie in the liver or the pancreas, or in some functional disturbance of the biliary tract. Usually, when the bile and the wall of the gall-bladder are normal, the gall-bladder is blue. Sometimes a deposit of fat under the peritoneal coat makes it a much lighter color, but this is not likely to be indicative of disease. Inflammatory adhesions can usually be distinguished from the peritoneal fold extending from the gall-bladder to the duodenum. Formerly, in studying the conditions of inflammation, a great deal of attention was given to the tension of the gall-bladder, and a tense, noncompressible gall-bladder was considered indicative of cholecystitis. This assumption is undoubtedly correct to a certain degree, nevertheless, recent investigations by Boyden, of Harvard, show that the gall-bladder becomes very tense at certain times, according to the amount and kind of food that has been taken. Boyden has shown, by experiments on animals, that a regular cycle takes place, and that after a period of starvation the gall-bladder is always tense. It is probable that the tenseness often noted, and usually attributed to inflammation, may be the result of starvation that may occur before operations on the gall-bladder.

It has been demonstrated that an operation on the gall-bladder may be justified from clinical manifestations alone. In general, such an attitude is dangerous because most operative procedures have failed unless they had a sounder justification. In the last few years I have been interested in the study of two groups of cases to determine the end-results of operations for chronic cholecystitis without stones. Immediately after operation, all specimens were examined to determine the diagnosis, and graded according to the classification of the pathologists. The case histories were reviewed and questionnaires sent to patients. One of the groups consisted of 100 cases and the other of 300. The observations showed that if a patient had a history typical of cholecystic disease, with characteristic colicky pain, his symptoms were relieved by removal of the gall-bladder, whether or not a definite lesion was recognized. The study further seemed to indicate that if cholecystitis was graded 1, and the clinical manifestations were definite but the disease unrecognizable at the operating table, cholecystectomy was followed by cure in a higher number of cases than in the cases in which the disease of the gall-bladder was graded 2, 3, or 4. If the patient's symptoms suggested chronic dyspepsia, or if the predominant features were soreness, tenderness, and aching in the side, the likelihood of cholecystectomy promoting cure was not great. Formerly it was believed that in a large proportion of cases symptoms of dyspepsia were the result of cholecystic disease. While this is undoubtedly true, nevertheless, removal of the gall-bladder for chronic dyspepsia gives a small proportion of satisfactory results.

It is greatly to be hoped that diagnostic accuracy will be enhanced by the use of the Graham-Cole method of roentgenologic examination. Until the method was evolved, little help was obtained from the roentgen ray. Certain roentgenologists and others believe that they will be able to recognize disease of the gall-bladder more accurately by this method than the surgeon can by exploration. This places a good deal of responsibility on the roentgenologist, but the fact that many patients have been relieved of their symptoms by removal of a fairly normal-appearing gall-bladder, affords some justification for this opinion. There is either some unrecognizable disease in the gall-bladder, or else its removal produces some change in the liver or pancreas, which relieves the symptoms. There are many possibilities for error in the new plan of roentgenologic examination in these cases, and the stage has not yet been reached in which a diagnosis can be made by this method alone.

The important problem is the development of a plan for the more accurate diagnosis of cholecystitis. The results of operation in these cases are satisfactory, as a rule, and the operative risk is low. The problem is much more serious when the disease becomes complicated with biliary cirrhosis, resulting in jaundice, or inflammation of the pancreas. The progress made recently in the handling of jaundiced patients can be attributed largely to McNee, who supplied us with a more workable classification of jaundice, and to van den Bergh, Aschoff, and Mann, who taught us much concerning the physiology of the liver and how to estimate the degree of jaundice. It has long been known that calcium produces certain effects on the coagulation time of the blood in cases of jaundice, but no great benefit was derived from such knowledge until

Walters made a careful investigation of the manner of using the calcium. The knowledge of how to estimate the degree of jaundice, how to use calcium, and the giving of an occasional blood transfusion in these cases, has reduced the mortality from an almost prohibitive level to one which holds much promise for patients in this serious condition. Something will eventually come from the tremendous effort that is being put forth in the study of tests of hepatic function, but so far surgery has not derived much practical benefit. By all odds, the most important test of the patient's condition is the van den Bergh test for the amount of bilirubin in the blood serum. This shows the exact degree of jaundice; repetition of the test indicates whether the jaundice is increasing or decreasing, which enables us to determine how much preparation is needed and what the risk of the operation will be.

There is no abdominal operation that requires as good exposure as one on the gall-bladder or bile ducts. The best exposure can be obtained by a fairly large incision which begins at the ensiform process and terminates a little to the right of the umbilicus. The important point is that the incision should be high, with the upper end close to the ensiform. Usually the suspensory ligament should be divided, as it affords not only better working space, but a fixed point on the liver, which makes it possible to lift the liver and retract the under surface. There is no question in my mind that it is much safer and better to perform cholecystectomy by beginning the operation at the cystic-duct end of the gall-bladder than at the fundus. In an occasional case the lower end of the gall-bladder and cystic duct cannot be isolated, in which case it may be better to start the dissection from above. After the gall-bladder has been removed, the cystic duct and artery should be ligated and dropped back away from the surface of the liver, and, if feasible, the gall-bladder fossa should be covered with peritoneum. Until within a few years ago, it was customary to use abdominal drains in all such cases, whether or not there was any infection or question as to the accuracy of the technic. I am much impressed with the results in cases in which closure has been made without drainage. I made this technical change gradually, but, after experience with several hundred cases without drainage, I am convinced that in the clean case in which the cystic duct is accurately tied and oozing absolutely controlled, closure without drainage is the safer and more satisfactory procedure. Statistical data concerning such cases in the clinic seem to prove this contention.

In cases in which jaundice is an associated condition, operation can be carried out with less risk if the abdominal wall is blocked with procain, and ethylene used as the general anesthetic, with as little ether as possible. In cases of deep jaundice, it is usually best not to remove the gall-bladder unless it can be done with little disturbance to the surface of the liver. If this is opened, considerable oozing follows, and the more these cirrhotic livers are sutured, the more profuse the oozing becomes. The result is that the wound has to be closed with the gall-bladder fossa packed with gauze, which is a poor procedure if it is possible to avoid it. It is essential to control all oozing if the patient is jaundiced.

A few years ago it was thought that little more could be learned about operations on the gall-bladder. Recent investigations, however, have opened up new fields and changed our conception of the physiology and function of the biliary tract, and now much more progress can be expected in the diagnosis and treatment of diseases which attack it.

"DEEP-ROENTGEN THERAPY"*

H. B. McEuen, M.D.,
Jacksonville.

Roentgenologists in speaking of deep-therapy, mean X-ray therapy carried out with voltages applied to the X-ray tube in excess of one hundred and fifty thousand volts. In most cases the voltages are in the neighborhood of two hundred thousand volts. The term deep-therapy originated for this variety of X-ray treatments to distinguish it from that using lesser voltages, such as from eighty to one hundred and fifty thousand, which is termed superficial therapy. In rays from a deep-therapy tube we have shortness of wave length comparable to the gamma rays of radium in their penetrative quality and with the same biologic effect. Our dosages are computed in per cent of the skin erythema dose and the erythema skin dose is that quantity of

*Read before the 54th Annual Meeting of the Florida Medical Association, West Palm Beach, April, 1927.

X-ray radiation that will produce tanning of the skin three weeks after the dose has been administered. Dessauer produced charts by measuring the quantity in per cent of the surface (skin) dose reaching different depths in the body and on these charts Wintz gives as the approximate dose for the following lesions in per cent of the erythema skin dose: Carcinoma, one hundred and twenty per cent; sarcoma, eighty to one hundred per cent, and fibroids, thirty-five to forty per cent. I had intended showing some slides explaining technique at arriving at these various depth doses and explaining more of the general technique, but my time will not allow this, so I will proceed to the most important part of my paper: "What can be treated with deep-therapy and what results can be expected?"

First to be considered will be idiopathic menorrhagia. I have had any number of these cases in which no pathology could be demonstrated, and which had resisted all forms of treatment, including in one case four curettements and in three or four others one curettement, with failure. These cases I gave forty per cent of the erythema dose over the ovaries and uterus, taking from two to four days to complete the treatment. Following treatment the flow gradually diminished and in most cases had ceased in from ten days to two weeks, none going beyond the following menstruation period, if it had just passed at time of treatment. There has been no failure in these cases. Patient will probably menstruate twice following such treatment and then go into a menapause. There is no danger from such treatment, no skin reaction whatever is produced nor are there any adhesions produced in the abdomen. Results have been one hundred per cent in my cases.

Castration: Dose as in menorrhagia, menstruation will occur probably twice, three times at most after treatment and then cease completely. In anemic patients the menstruation often stops immediately after treatment. Such castration produces no scars or adhesions. The resultant menapause is less severe in its reaction on the nervous system than when a surgical castration is performed, i. e., the ovaries removed. Results are one hundred per cent.

Menapause: With flooding periods of ten days at a time and frequent return of flooding, often there being only two to four days between, over periods of months and sometimes years, with its constant drain on the system and great worry to the patient, can and should be stopped. The deep-therapy dose is the same as in fibroids or in menorrhagia and will terminate the menapause in from thirty to sixty days, and will lessen the flooding in ten days and control it in not over twenty days. Results in uncomplicated cases are one hundred per cent.

Fibroid uterus: Excellent results can be expected from deep-therapy in treatment of fibroids. I have had any number of cases in which the tumor ranged in size from one's fist up to the size of a full-term pregnancy with uniformly good results. It takes from one to four series of treatments to cause a fibroid ten inches in diameter to completely regress. Such treatments are given four to six weeks apart and consist of thirty to forty per cent of the erythema skin dose delivered to uterus and ovaries.

These treatments do not confine the patient to the hospital nor does it take them from work. I recall one case I treated. A trained nurse, who had a fibroid ten inches in diameter, who remained on duty with a patient during the course of treatments. Treatments spoken of consist of a series of exposures of twenty-five minutes a day for four days. Such treatment, of course, produces the menapause. Results to be expected in simple fibroid uteri are one hundred per cent.

Malignancies: Carcinoma, sarcoma and melanomas. In these patients we have disease that so far has been insurmountable and it is best for all to cooperate in treatment to get the best end results. The urge of recent years has been to diagnose these cases early and I think that all are familiar with this general propaganda of the American Cancer Research. It is quite true that the early case has a greater per cent of cures over any given length of time and I would again caution against delay in any growth that is at all doubtful. I am urging that these early cases be given preliminary or best, say, pre-operative X-ray radiation as I feel that the patients are not getting all that they should be getting when the surgeon goes ahead and operates the supposed clearly operable case without radiation. I will show from statistics of a reliable source that the per cent of cures over a five-year period, in over eight hundred breast carcinomas, which had both radiation and operation, doubled the per cent that had operation alone. Since I located in Jacksonville I have found the surgeons very reluctant in referring carcinoma patients to the rœntgenologist for pre-operative radiation. Yet

I had one of our best surgeons make this remark to me: "I do not know of a single case of breast carcinoma that I have operated upon that is alive three years." This was about one year ago and so far I have not had a single case that was not entirely hopeless from an operative standpoint, referred to me for treatment from this surgeon. In Jacksonville it is almost an every-day procedure to cauterize a carcinoma of the cervix and do a panhysterectomy, with its high mortality, and as an end result have approximately twelve per cent cures (less, I would say,) over a five-year period. There are any number of authors on record who report from forty to eighty per cent over a like period from radiation in cases which were considered operable, i. e., cancer still confined to the uterus. Twenty-five to forty per cent, when the clearly operable and the borderline cases are classed together, and from one-half of one per cent to six per cent of the clearly inoperable, hopeless cases are treated by radiation alone. These results are obtained from deep-therapy, or from radium or from combining deep-therapy and radium. If these patients are to be operated upon in face of such results, they should be at least given the benefit of pre-operative radiation.

In carcinoma of the breast, the patients are operated upon as soon as a mass is found, without proper examination to see if there is metastasis to the lungs or mediastinum. Such procedure should be condemned. I recall a patient who was admitted to the hospital for treatment of shortness of breath and on the physical examination a small lump was found in the left breast. This mass was the size of an English walnut and was freely movable and alone would have been considered clearly operable as there were no glands in the axilla, but the X-ray film showed massive carcinoma metastasis to both lungs. Operation would only have hastened her death. I do not think that a patient who has a carcinoma of the breast is getting the best attention, when it is operated upon without a preliminary film of the chest to ascertain if there is metastasis or not.

"When carcinoma of the breast can be diagnosed while it is strictly localized and therefore can be completely removed, I believe that immediate excision is the proper treatment. Unfortunately, only a small percentage of cases are operated upon in this stage." In a recent report from London (Leeds), by Dr. Janet Lane-Clayton, only seventeen per cent were in this early operable stage, or one in six cases. Therefore, in about five out of six we must realize that the disease has spread and in these cases radiation and operation can be combined to an advantage. As shown by statistics of Pfahler and Widmann in a series of over eight hundred cases of breast carcinoma in the operable class in which radiation and operation were used together, the per cent of alive at the end of five years was sixty-eight (no glands) and forty-six per cent in those cases where there were glands. The general average of recoveries from operation alone in cases that are clearly operable (no glands) are variously reported as being forty-seven to one hundred per cent, while in those in which glands are present, various claims are made from four to forty per cent. The general average is about twenty per cent. If, however, operation is combined with pre-operative radiation, the five-year cures are increased, as reported from various authors, to from thirty-six to forty-six per cent, or about double that from operation alone.

Sarcomas: I will not have time to go into details on sarcoma as to statistics and so forth. As a rule sarcomas respond very readily to deep-therapy radiation and life can be greatly prolonged by such treatment, especially of the glandular types. Large metastasis in the lungs may be controlled for years. I will give you a brief outline of a case of fibro-sarcoma now well four years after being classed as entirely hopeless at operation. As an example of what may be accomplished in the sarcomas, Miss G., operated for large fibroid. On opening abdomen, mass was found to have invaded omentum, small intestine, colon, urinary bladder, uterus, rectum, and the abdominal wall. A specimen was taken and patient closed. Pathologist's report was fibro-sarcoma. She was then referred to me two weeks after operation for deep-therapy treatment. At that time the mass was the size of a full-term pregnancy, reaching the ensiform and both iliac spines and patient weighed one hundred and fourteen pounds. She received several series of treatments over a period of nearly three years and when I saw her last (two months ago) she looked to be in perfect health, weighing one hundred and sixty-five pounds. On physical examination she shows a very small mass in the left ovary region which has not varied in size for the past year.

I had planned to have a patient here to show

you—a Mr. Bright, of Gainesville—but on account of business reasons he was unable to attend. Mr. Bright had a growth in the right side of his neck, close up under the mandible, and was operated upon by Dr. Nobles, of Pensacola, a little over three years ago. On exposing this mass, Dr. Nobles reported that it was tarry black, and he removed it as completely as possible and sent tumor to Dr. Funke, in Atlanta, for examination, and by the time report was received, mass had re-occurred to its original size, mass was approximately the size of a hen's egg. The pathologist's report was melano-sarcoma. He was referred to me for radiation and he received a very intensive radiation from the deep-therapy machine, and two weeks later I gave him, directly over the growth, a supplemental dose with lesser voltage and with aluminum filter of approximately three times the erythema skin dose for the filtration and voltage used. In two or three days he had a very violent skin reaction. His tongue swelled until it filled his mouth and protruded, and he was very sick from the reaction for ten days. In one month's time from time of beginning of treatment there was no evidence of growth remaining. He has not had any further treatment and today he is still well, without any evidence of recurrence or metastasis. This case is remarkable in that Dr. Bloodgood has reported over five hundred cases of melanomas in which there is only one now living, and this case was a skin melanoma excised seven years ago. Dr. Bloodgood has slides of tissue from two cases cured by X-ray radiation, and reported by Dr. Wainwright. In all I have come in contact with four cases of melanoma. The above one. One of the foot, in which there had been three or four attempts at removal, with prompt recurrence. I rayed it rather superficially in comparison to Mr. Bright's case, with no effect. His leg was amputated in the groin and he died in less than six months. Another: Mrs. D. Large melanomas of skin of breast, with several nodules in breast. Very intensive radiation was given her, with regression of the superficial melanomas, and, thinking that in this regression they would not again show extreme degree of activity, I advised removal of breast. This appeared to stimulate growth, and no amount of radiation appeared to have any effect whatever. She died in less than six months' time. The other case was in a man, skin type, at outer canthus of eye, growth had doubled its size in months' time. It was given a caustic dose of unfiltered rays, and when last seen, two years after treatment, there was no sign of return. I would strongly advise against excision of any black mole or tumor mass (melanoma) as they all appear to die. X-ray offers these patients more than any other form of treatment, and it should be given intensively.

Discussion

Dr. C. J. Marshall, Sanford:

There is very little indeed that I can add to Dr. McEuen's excellent paper. He has covered the subject in a very conservative way. I simply wish to add my plea that more cases be referred for pre- and post-operative radiation. As Dr. McEuen has stated, there seems to be a great hesitancy on the part of surgeons to refer borderline cases or mild cases to the roentgenologist. But if an inoperable case comes along, why "yes, you had better go see the X-ray man." If X-ray and radium are beneficial, or may be conceded by the surgeon to be slightly beneficial, in the inoperable cases, why doesn't it stand to reason that in connection with surgery radiation will be beneficial in all cases?

I think Dr. McEuen stated that the high voltage X-ray in therapy was comparable to the hard, or gamma, rays of radium. It is, and I think it is more effective than radium in most cases unless you have an immense quantity of radium, and few of us have. I think you get better results from 200 k.v. X-ray radiation than from small quantities of radium in the ordinary conditions in which radium is indicated. The ordinary amount of radium that is available is usually so small that you only get a small localized effect unless the time required to apply it is exceedingly long. For this reason, I advocate deep X-ray therapy in a great many conditions where radium would otherwise be indicated.

Another thing, in regard to treating these conditions of menorrhagia by radiation to produce artificial menopause: As Dr. McEuen has stated, and as the preceding paper indicated, the X-ray nowadays is developed to such a stage that we know exactly what we are doing. We can gauge the dose of X-ray just as well as the pharmacist can measure a drug. Frequently it is advisable to produce a temporary menopause. This can be done. So many people are afraid to bring about a menopause on account

of the nervous reaction, or for some other reason, and in that case the dose can be cut down so an amenorrhea can be brought on for six months, a year, or two years, as the case may be.

The X-rays are, in my opinion, practically always beneficial for hemorrhages from the uterus, unless it is some other specific condition, i. e., a case of mine a few months ago where I used the X-ray for what was supposed to be a menorrhagia, and produced no effect whatever. On investigation, surgically, there was found to be an ectopic pregnancy. Of course, the X-ray is not specific for a condition of that kind.

Another thing, you get quite a severe reaction from deep therapy, especially where the abdominal organs are included in the field of radiation, and for that reason most of these treatments should be given in broken doses. A great many men, in referring cases to a roentgenologist, say, "Well, go and get a dose of X-ray and come right back." We have to graduate these doses and divide them over a period of time to avoid the very severe reaction which would otherwise take place.

Dr. W. McL. Shaw, Jacksonville:

I want to thank Dr. McEuen for bringing this subject up. I am sorry he did not have time to finish it. I would like to lay stress on two points he brought out in particular.

First, the pre-operative X-ray examination of cases suspicious of malignancy. A surprising number will show metastasis already in the lung, if you will take the trouble to look for it, and you surgeons will cut down your mortality if you will do that one thing, because you go and operate, and then the patient dies from metastasis. They get well from the operation, but die from the metastasis. I don't think we can stress this point too much.

The other point was pre-operative therapy. Just one case I recall at present, because I had contact with that patient today. About three and a half years ago, a case came to Dr. Cunningham and myself for a mass in the breast. She had already been X-rayed, and one large, egg-shaped metastasis demonstrated in the lower lobe of the right lung. Another smaller one, about the size of a marble, was also found. The outlook was very grave and she was given intensive X-ray therapy. A month or two later the breast was removed, as much for the psychic effect as anything else. She has been X-rayed three or four times since. Today I happened to meet her husband here in the hotel, and he said she was doing fine. It was three years ago last July the metastases were first demonstrated in the chest, but she is well today. I think if that pre-operative film had not been made, and the metastases not discovered, she would not be living today.

If you will carry away these two points from this paper of Dr. McEuen's, namely, pre-operative X-ray examination and pre-operative X-ray therapy in malignancies, I feel that your time will have been well spent here.

Dr. J. E. Boyd, Jacksonville:

I wish to take issue with the rather dogmatic position of this paper. I employ deep X-ray therapy as freely as any surgeon in the state, and I refer all cases of malignancy, prior to operation, for a roentgen study referable to metastasis.

I am convinced that surgery is the most essential treatment in malignancy. This statement, however, is not intended to belittle the value of X-ray treatment.

After having had my patients receive pre-operative roentgen therapy for a number of years, I am not convinced that it is either necessary or valuable. Post-operative roentgen therapy is still being recommended by me.

If there is any one thing of special value known today about malignancy, it is the fact that for some time in its incipiency it remains *localized*. If, during this time, you remove, by excision, all the malignant tissue, I believe you will permanently eliminate your disease. I am not convinced that treatment by X-ray or radium alone offers so sure a cure.

When a case of malignancy is inoperable or beyond the realms of cure, it is our duty to apply any measure which will add to the comfort of the patient. This is ample reason for referring such cases for radium or X-ray therapy.

I would like to ask the essayist if he feels that X-ray or radium can cure any case that surgery would fail to cure.

Conclusion

Dr. H. B. McEuen, Jacksonville:

I went to the trouble of writing Dr. Joseph Bloodgood, of Baltimore, before forming much of an opinion myself of having cured a few cases that appeared hopeless for surgery. He states, in his letter: "In regard to cancer of the

cervix, the majority of authorities prefer radiation to any operation, and I am inclined, from my experience, to take this view."

In this case of melanosarcoma I cited, surgery failed in that, and in the fibrosarcoma, surgery could not touch it because it involved the omentum, small intestine, bladder and rectum. Apparently the patient is well today. I think the surgeon condemning deep-roentgen therapy just simply has not had the experience with it he should have had.

THE RATIONALE OF ROENTGEN RAY THERAPY IN DERMATOLOGY*

ELMO D. FRENCH, M.D.,
Miami.

The use of the Roentgen Rays as a therapeutic agent in dermatology, necessitates an appreciation of its mode of action before certain objectives are obtainable. In part this is founded upon clinical experience, but in larger part it is dependent upon a well-defined and constant influence upon living tissue. In the same manner as the old "shot gun" method of drug prescribing has largely passed into oblivion, and through an appreciation of pharmaco-dynamics, the modern physician is a better master of disease. However, the action of mercury, in syphilis, for instance, is little understood, but bears the proven value of many years of clinical experience.

To a degree, the Roentgen rays are used in an empiric way on certain conditions in which experience has found its action unexplained but useful, and again it may fail where it is expected to succeed.

The writer would have it distinctly understood that he by no means regards the X-ray in the nature of a panacea in dermatology. He feels, on the other hand, that in the majority of instances, where its application would seem rational, it is as an adjunct to treatment and has no place in the hands of those who care little for the cause of the disease nor for other proper therapeutic measures, for only in certain instances are the action of the rays, alone, curative. Nor should it be necessary to state that we must always be on guard lest it prove to be a two-edged sword.

All human tissue, normal and pathological, is affected by the Roentgen rays.

*Read before the 54th Annual Meeting of the Florida Medical Association, West Palm Beach, April, 1927.

The rational of Roentgen ray therapy is based on the susceptibility of pathological tissue being greater than that of normal tissue, except when the mechanical action of the rays is sought, as in the removal of infected hair. The effect produced varies directly both as to the quantity of the rays and the cellular structure of the tissue treated. Other factors, such as the locality of the lesion and the constitutional reaction of the individual patient, play a less certain but important part. It is the relation of the tissue structure to the results obtained that we wish to consider here.

While remarkably versatile in its action, as shown by the fact that such widely different diseases as acne and carcinomatosis are favorably influenced, there are a sufficient number of common denominators among the lesions affected to account for this versatility.

On the other hand, there is much about the action of the rays which is yet to be known, and sometimes in lesions pathologically closely similar one may undergo quick resolution and the other remain unaffected by the rays, as, for favorite example, in psoriasis and parapsoriasis.

Acne is essentially an inflammatory hyperplasia of the sebacious glands. There is exaggerated cell division occurring, often plugging the gland outlet, causing a comedo. There is a concomitant hypersecretion of the glands, resulting in an oily skin. Secondarily, the glands are infected with the staphylococcus albus and acne-bacillus, and a marked inflammatory zone occurs about the glands. By its inhibitory action on cellular reproduction and on the secretory activity of the sebacious glands, the Roentgen rays, in conjunction with other proper constitutional and local measures, is regarded today as a safe and efficient treatment for acne in the hands of a careful operator.

SEBORRHEA, SEBORRHEIC DERMATITIS AND SEBORRHEIC ECZEMA

Likewise in these dematoses which are marked by morbid changes in the secretory activity of the sebacious glands, the value of the Roentgen rays as an adjunct to treatment is in direct ratio to the degree of inflammatory reaction present. In those cases of seborrhea where the pathology is represented simply by an oily skin, the effect is to inhibit gland function and hyperplasia, and is not as proportionate as in seborrheic dermatitis or seborrheic eczema with involvement of

all the elements of the skin in an inflammatory process. For to quote Highman and Rulison "in inflammatory diseases, the hyperplasia of the epidermis is influenced by the inhibitory effects of the rays on the reproducing cells, and the infiltration by the destructive effect on the infiltrating cell as well as on the reproducing fibroblasts."

PSORIASIS

The cause of psoriasis is unknown and its treatment more than often disheartening. The battle, in the light of our present knowledge, should be the management of the disease rather than an attempt to cure. There are many diseases as, for example, diabetes and chronic myocarditis, which only the extreme optimist would hope to cure.

The lesions of psoriasis, as a rule, considering the intensity of the process, are remarkably susceptible to removal by keratolytic chemicals and by actinic therapy, as sunlight, or the X-rays. A partial explanation for this sensitiveness is probably the predominance of lymphoblastic elements in the histopathology of the psoriasis lesion and the very rapid proliferation of the rete cells. The fibroblastic elements play comparatively a minor role. There is no scarring in psoriasis. No explanation why some cases are so resistant to X-rays has been found. Most cases develop a decided resistance to the rays, requiring unwarranted and dangerous doses to produce exfoliation.

DISEASES DUE TO FUNGI

The writer is firmly convinced that for variety of clinical appearance and as an imitator of other dermatoses, the ringworm fungi is a very close second to syphilis. There is not much doubt that no other disease to which flesh is heir has approached the incidence of this affection in one form or another. In ordinary ringworm of the glabrous skin, as tineacircinata and tineacuris, only the corneous layers of the skin are involved, and the Roentgen rays are not indicated.

In the so-called eczematoid ringworm, the Roentgen ray is of value. The sites of predilection are the hands, chiefly the palmar and interdigital parts, the feet, chiefly plantar and between the toes, and the crotch between the thighs and on the scrotum.

The histopathology is usually a hyperkeratosis, papillary congestion, edema and vascular dilatation. By the action of the rays in suppressing the hyperplasia and secretory activity of the skin, the growth of the organism is, in a measure, suppressed. In a considerable experience, I have never seen this form of ringworm cured by X-rays alone.

In the deep-seated type of ringworm there is marked leucocytic and plasma cell infiltration, and in aggravated forms, true granulomata occur. This type often approaches a carbuncle in clinical appearance. The Roentgen rays are curative.

In ringworm of the nails, the effect of the Roentgen rays is variant, and the action is not understood. A considerable number are permanently cured.

In ringworm of the scalp and beard, the so-called mechanical action of the Roentgen rays produces a cure by depilation. Here the hair follicles and hair shaft are attacked by the fungus. The removal of the hair carries a large number of spores with it and the remainder are readily destroyed. In this condition the Roentgen rays are, without question, the treatment of choice and a triumph of modern technique.

In blastomycosis, actinomycosis and sporotrichosis, which are due to varieties of fungi, the Roentgen rays are said to be almost specific. Through the destructive action of the rays upon the hyperplastic elements in these granulomata, a resorption takes place.

INFECTIONS

In superficial pyogenic infections, as impetigo, with no marked hyperplasia nor infiltration, the Roentgen rays are without demonstrable effect. In the deeper seated pyogenic infections marked by hyperemia, cellular infiltration and multiplication of tissue elements, resolution is usually markedly hastened and pain often completely relieved through a single application of the Roentgen rays.

During the late spring and summer months crops of axillary furuncles, with a distressing tendency to recur, are not uncommon. The Roentgen rays seldom fail to relieve and to stop these recurrences. The same is true of furuncles on the back of the neck in men, and now more often in women, since they are shaving their necks.

In a series of cases referred by eye, ear, nose and throat specialists, with recurrent furuncles in the external auditory meatus, some of them

long-suffering, a check on the case with the consultant has almost invariably shown, after a single exposure to the rays, results as follows:

1. Marked relief from pain within 36 hours.
2. In some cases resolution occurred without suppuration.
3. In other cases, suppuration was markedly hastened.
4. Recurrence in the ear irradiated did not occur.

Just what the effect on the inflamed tissue might be in these cases is only speculative. As has been suggested, the action is too quick for any demonstrable effect upon the cellular morphology. The writer does not wish to convey the impression that he would advocate the Roentgen rays in the vast majority of pyogenic infections, nor that any measure should take the place of surgical drainage when indicated.

Certain bacillary infections, as tuberculosis and leprosy, will not be discussed. In those infectious diseases which are due to any variety of animal parasites the Roentgen rays are of no use. In syphilis, which is due to a protozoon, there is, of course, no reason to use the X-rays.

In the group of diseases, Mycosis fungoides, Leukemia and Hodgkins, classified as the non-infectious granulomata, and in some manner related to lymphosarcoma, the Roentgen rays offer great symptomatic relief. In the structural pathology are rapidly growing, undifferentiated cells, and the response to the ray is spectacular. Life and comfort are prolonged, the disease is not cured.

ATROPHIC CONDITIONS

Conditions which lead to eventual atrophy, as lupus erythematosus and scleroderma, parallel, in a measure, the changes characteristic of chronic X-ray dermatitis, and in such conditions Roentgen ray treatment is not rational.

FUNCTIONAL DISEASES

Hyperhidrosis, or excessive sweating, when confined to certain regions, as the hands and feet, may be permanently cured by the Roentgen rays. A sufficient number of sweat glands may be caused to undergo atrophy so that the amount of sweat is reduced to normal.

Pruritis, either anal or vulvar, is amenable to treatment by the rays. A certain number may be cured by the rays alone. In those cases, which are infectious, as, for instance, due to the mycelia, it is only an adjunct to patient, persistent treatment. How the rays act to relieve itching is not known.

NEOPLASTIC DISEASES

Here the law of Bergonie and Tribondeau, that "immature cells and cells in an active state of division are more sensitive to the X-rays than are cells which have already acquired their fixed adult morphological or physiological characteristics," finds its most acceptable application. Also, according to Satenstein and Remur, "neoplasm elements vary according to the type of tissue from which they originate. Those of the highest type (epithelial and glandular) are the most resistant and least readily influenced of all pathologic cells", and, again, they state that the degree of involution depends in part upon the amount of highly sensitive lymphoid, or connective tissue elements, which is present as part of or about these pathologic processes.

Non-malignant neoplasms which, as a rule, are composed of well-differentiated mature cells not undergoing rapid proliferation and running true to type, are little affected by radiation.

Exceptions occur, however, as in plantar warts, juvenile warts and callosities which are marked by dyskeratinazation and marked proliferation of the basal-celled layer, and a surrounding hyperemia with round-cell invasion and connective tissue hyperplasia. They are, as a rule, easily cured by the rays.

Of the vascular nevi, which are congenital neoplasms, the angiomatous type is made up of proliferative endothelial cells, embryologic in type, and while, to a degree, susceptible to the X-rays, show a selective response to radium.

Keloids are affected by the action of the Roentgen rays in doses which approach that of skin saturation. The proliferating, white, fibrous tissue, characteristic of keloids, is resistant but may be inhibited by the rays.

Malignant neoplasms, of whatever type or origin, show a variant but marked and favorable response to the Roentgen rays. The factors which in part govern this response have already been stated. Other factors, such as the age and constitutional reaction of the individual and the locality of the lesion, will not be considered here. There is much left to be explained.

The relative value of any method of attack on malignancy will not be discussed—each has its place and limitations which must be recog-

nized. It has been claimed by some that the Roentgen rays will at times stimulate the growth of malignant tissue. The idea of stimulation by the rays was used to explain its exfoliative action on squamous and scaly forms of dermatoses. Those diseases, so characterized, are marked by an active proliferation of the germinal-celled layer. The inhibition of this proliferation and the action on the infiltrating cells is certain, and would account for the subsequent exfoliation.

The writer cannot find any convincing evidence, clinically, nor in the literature, that malignancy is ever stimulated by the Roentgen rays. That malignant cells may develop increased resistance, or at times be unaccountably resistant to the rays, is another matter, but actual increase in malignancy, while occurring in the treated as well as untreated cases, is an inherent characteristic which has not been explained. Among others, Crutchfield, of Galveston, has searched the tissues for any evidence of a stimulating effect which could be ascribed to the Roentgen rays without success.

CONCLUSIONS

1. Roentgen rays have a place capable of evaluation in dermatology.

2. Their use is more often as an adjunct to treatment, though, at times, curative, and in a large group of conditions it has no place.

3. A sufficient number of dermatoses are discussed to illustrate the versatility of the action of the rays.

4. Whatever the cause, those conditions marked by cellular multiplication of the tissues are most apt to respond.

5. The chief uses of the rays are to inhibit or destroy secretory or cellular activity, or the mechanical action in removing hair.

6. The rays appear at times to be bacteriostatic rather than bacteriocidal in action, the inflammatory tissue itself mainly being affected.

7. The idea of stimulation by the rays is challenged.

DISCUSSION

Dr. J. L. Kirby-Smith, Jacksonville:

Dr. French's paper on "The Rationale of Roentgen Ray Therapy in Dermatology" is very apropos at this time and covers the subject very thoroughly. I suppose for twenty-five years the X-ray has been used in the treatment of skin diseases. Every year the technic is modified, its methods of use, measurement, etc. A dosage of X-ray can be calculated as exactly as a dose of anything else. The effects on the skin of X-ray have been tested out scientifically; we do not know what the substance is, but those who use the X-ray can, with accuracy, control it. I don't care if it is in dermatology, taking a picture or deep therapy. But in the treatment of skin disease it is more successful than any other measure. Of course, it is misused. I have done it myself—burned myself on the leg not long ago, but that was my fault and not the fault of the X-ray.

I have been using X-ray myself for twenty-one years. You can absolutely work out the dosage of the X-ray with your distance, time, voltage, etc., so that you know what to expect. There is no guess-work about it. In skin diseases, it is the most valuable measure that can be used. You can control the use of it. Its great value is that it retards secretions. If you have a sprained ankle, for instance, and the skin area is swollen and, due to strapping, becomes wet, inflamed, infected and tender, you will find that X-ray treatment will lessen secretion and the patient is comfortable. The same is true in skin lesions, the use of the X-ray depresses the glandular secretions and in this way burning and itching is controlled, and the patient is more comfortable.

Because we can calculate the difference in the time necessary to produce a certain result on normal tissues and on abnormal tissues, we are able to estimate the dose necessary to destroy malignancy. As I have said before, the dosage is absolutely calculated as accurately as any possible scientific measurement. You know how many minutes it will take to burn the skin and how much to destroy malignancy, and you are not working on something you don't know anything about, as far as dosage is concerned.

THE VOMITING IN PREGNANCY*

HOMER L. PEARSON, M.D.,
Miami.

In presenting to you a paper on this subject, I realize that to cover it as it should be covered would constitute a paper of too great length, and, I fear, would become tiresome, for there

*Read before the Dade County Medical Society, April 6, 1927.

is much theory and few known facts in connection with the etiology and the treatment of the vomiting of pregnancy, yet in the past few years we feel that much progress has been made along this line. I wish to present to you briefly some of the outstanding theories of the causation and a practical treatment of this disease.

In reviewing the various authorities on obstetrics, it was surprising to me the number of them who had a tendency to touch lightly on this condition of such great importance, both to the practitioner and to the expectant mother. I believe with Dr. Carter, of New Orleans, that "indifference to the vomiting of pregnancy, by looking upon it as a natural physiologic consequence of the pregnant state, has lead to many catastrophies. That the pregnant woman must vomit, a theory casually accepted by many physicians, is erroneous, for, according to statistics, some two-thirds do not, though why some do and others do not is a problem still unsolved, but we should never look upon it as a physiologic condition, and it should be treated as pathologic from its beginning." As to the causation of the vomiting of pregnancy, there are theories being constantly advanced which are too numerous even to enumerate, therefore I will attempt to outline only some of the most important: "The simple nauseas of pregnancy may be due to various factors; as neuroses of various types, displaced uteri, cervical erosions, adhesions, or even constipation, which type is frequently checked by simply suggestive measures, or gradual dilitation of the cervix, replacing a displaced uterus, treatment of the cervical erosions, etc. If this type of nausea responds to this treatment, it seems to prove that the condition is not essentially a pathologic one. However, when the discomforture passes beyond this stage, and the vomiting becomes more than the once-a-day or early morning type, we are dealing with a pathologic condition and must, therefore, look for the etiology and a successful treatment of the disease."

We have another type to consider here, which is that of the dissatisfied mother who does not wish pregnancy, and who thinks if she becomes sufficiently ill she might get it interrupted. We must watch carefully for this type, because at this time they are quite numerous. We must also realize that she can vomit and refuse nourishment until her condition will become serious, due to a starvation acidoses. These cases are sometimes our most obstinate ones because of the lack of cooperation of the patient. With a little psychology, however, she can usually be treated successfully.

Let us here glance briefly at some of the theories which have been advanced to explain the more serious nauseas and vomiting of pregnancy. "Bourne, of Great Britain, believed that a toxin is constantly being produced by the growing ovum and is absorbed by the maternal circulation, thus the ovum constantly poisons the mother, but in all healthy mothers, most of the toxin is counteracted by their own immunizing efforts. Schnoll proved that foreign fetal protoplase was conveyed into the maternal circulation when he demonstrated the presence of small pieces of syncytial protoplasm in the circulation, and he agrees with Bourne that a biologic defense is set up by the maternal tissues to battle the invasion. Hofbauer emphasizes the fact that the pituitary and suprarenal glands play an important part in the nauseas of the pregnancy, and adds that the harmones from these glands affect the brain, kidneys and stomach. He, therefore, considers ovarian extracts almost a specific for this pathology, claiming that it inhibits the action of the pituitary and suprarenal glands on the sympathetic nervous system and paralyzes the excessive functioning of the pituitary-suprarenal system." Hirst places the cause in the lack of corpus-luteum and advocates the intravenous and hypodermatic use of this substance. Titus, Givins and Harding believe that there is a carbohydrate deficiency in pregnancy, due to the fact that the fetus and placenta require large quantities of carbohydrate for their growth and that this deficiency exists until the pancreas and liver of the fetus are sufficiently developed to function. Thalhimer believes that there is a change in the carbohydrate metabolism. Sellers believes that all cases of persistent vomiting of pregnancy are associated with a varying degree of toxemia. The toxemia starts nausea and vomiting, associated with a slight acidoses. The disgust for food and the inability to retain food if eaten, causes a starvation acidoses which naturally intensifies the nausea, thus constituting a vicious cycle.

In reviewing these causes for nausea and vomiting of pregnancy, as brought out by these various authorities, the one conclusion that we must form is that, as yet, we cannot put our finger on any one thing that might cause all

cases of hyperemesis gravidarum, but that any one of the foregoing theories might be correct in certain cases. In other words, pernicious vomiting of pregnancy is not due to a single etiological factor. There are certain points, however, that we can accept as facts. The first is that in practically every case we are dealing primarily with a case of acidoses, as evidenced by the breath, the urine and the vomiting. Second, there is, in the fatal cases at least, a degeneration of the liver, identical with acute yellow atrophy, and since the liver has to do primarily with carbohydrate metabolism and the storage of glycogen, we can be positive in these cases, at least, there is a carbohydrate deficiency as well as a marked change in the carbohydrate metabolism.

Before we attempt to outline a treatment, we wish to bring out forcibly this point, that no matter what explanation we accept, one point is clear. The old axiom "An ounce of prevention is worth a pound of cure" was never more true than in the vomiting of pregnancy. "The maternal organism is already under a definite strain, and any pathology, no matter how slight, adds still further strain, so that disaster may result unless effective methods are employed as soon as possible. This cannot be too much stressed, because of the treacherous nature of the disease. It is apparently a simple, unimportant matter; the response to simple measures is usually good, and too many women are prone to accept it as the inevitable state and, often, almost before it is realized, a grave patheology has arisen from what was originally considered a minor discomforture. To prevent the simple from becoming the complex, by careful watching and by treating the condition in its incipiency, especially in the nausea state, should therefore be the criterion of any system of treatment which is advocated."

In discussing the treatment of this disease, I am somewhat at a loss to know just where to begin, because there are as many or more treatments as there are theories for its causation; therefore, it is useless for me to attempt to go into all of them in detail, but will discuss only that with which I have been most successful.

In the nauseas of pregnancy, as in all other diseases, we get best results when we see the patient early in the course of the disease. The majority of women are learning this and go to their doctors early. Therefore, when we see

(Continued on page 298)

RED URINE

J. A. Mease, Jr., M.D.,
Dunedin.

The color of urine greatly varies in health and disease. Ordinarily, a red or pink urine is suggestive of either blood or the ingestion of some pigment-bearing food or drug. Of foods most commonly encountered causing red urine are those of logwood, madder, bilberries and fuchsin.* Red beets contain the pigments (anthocyanins) which are unstable and usually broken up during metabolism, but may cause the urine and blood sera to become colored red.[1] This is probably due to the same cause as the yellow color of urine and blood sera after the ingestion of carrots (carotinemia). Drugs which may cause a red urine upon the addition of an alkali, are the pigments found in senna, rhubarb and chelidonium.[2] Phenolpthalein may also cause a red urine upon the addition of an alkali. The anthocyanins change color with a change in reaction and have for this reason been proposed as indicators. However, this phenomenon did not occur in the following described urine.

The specimen was from an apparently healthy male child, five years old, and was voided a few hours after he had eaten a large quantity of red beets (beta vulgaris). The urine was acid, clear, brilliant red, sp. gr. 1012. Tests for albumin, sugar, diacetic acid and acetone were negative. The guaiac test for blood was negative. The microscopic examination revealed an occasional leucocyte and epithelial cell. No casts or blood corpuscles were seen. The addition of acetic acid, nitric acid and ammonia had no effect on the color. Boiling, likewise, had no effect on the color. The child had taken no drugs. Red beets were suspected of being the cause, so one week later the child was again fed a large quantity of red beets, and within four hours the urine was again colored a brilliant red, which faded to pink, then brown, then yellow within twenty-four hours. The chemical and microscopic examination was negative. The addition of acids and alkalis, as before, did not change the color. The blood sera was not examined. The ingestion of red beets has been restricted and there has been no recurrence of red urine.

Of interest, also, is that the father, who has an arrested case of pulmonary tuberculosis, is also similarly affected by eating large quantities of

red beets, but to a less extent. His urine sometimes becomes colored a light pink after eating red beets. No one else in the family, on either the mother's or father's side, have been so affected.

*Hawk Practical Physiological Chemistry, Sixth Edition, Page 387.

1. Cummer Manual of Clinical Laboratory Methods, Second Edition, Page 289.

2. Hawk Practical Physiological Chemistry, Sixth Edition, Page 387.

KIDNEY AND BLADDER STONE*

G. F. Highsmith, M.D.,
Arcadia.

Stone of the urinary tract may be located in the kidney tissue, calices, pelvis of the kidney, ureter, bladder or urethra. The stone may be large or small, varying from the size of a mustard seed to that of a lemon.

Etiology:

In studying the cause of stone I wish to begin with the discussion of the blood stream. We know that the blood is alkaline in reaction. This alkalinity may vary under certain conditions of the body with regards to food, general health, and infectious diseases, such as typhoid fever, tonsilitis, bad teeth, syphilis. We will note the histology of the kidney shows the afferent vessels enter the capsules of the malpighian body as an artery and form the malpighian tuft. The blood is relieved from the tuft through the efferent veins. This is the point at which the blood begins to throw off the by-products of metabolism in the form of urine. It has been found that water sugar, and other readily difusible substances are excreted by the glomerelia, while urea and uric acid are excreted by the epithelium of the tubules. It is here that stone formation may begin. The fluid in the blood is alkaline and when excreted as urine it is normally acid. That is the fact which has been a point of study with me. Urine is acid due to acid sodium phosphate. It is important to the welfare of an individual that the blood releases these by-products at this point as normal by-products. They should be in perfect solution and that an acid solution. Therefore a diet, improper, toxin from constipation, high fever as by infection, etc., are factors of stone formation because they change the blood and its products of elimination are consequently changed.

*Read before the DeSoto-Hardee-Highlands County Medical Society, May 10, 1927.

The composition of urine normally in 24 hours, 1440 grams water, sodium chloride 16.5 gm., and 35.00 gm. of urea and salts and creatinin.

Urea	35.00 gm.
Uric acid	.75 gm.
Phosphoric acid	3.5 gm.
Sulphuric acid	2.0 gm.
Ammonia	.65 gm.
Creatinen	0.9 gm.
Potassin	2.5 gm.
Sodium	5.5 gm.
Calcium	0.26 gm.
Magnesium	0.26 gm.
Chlorine	11.00 gm.

These constituents are in solution at 98 and generally in certain proportions according to the diet and health. We see then when calcium oxylate crystals are in great quantity and not in proper solution while still in the kidney tubules, after a period of time they cause irritation of the kidney mucus membranes resulting in a mucus exudate which cements the crystals together and start a tiny stone. On the other hand, begin at the mouths of the urethra. We may have an infection as gonorrhea or other pyogenic bacteria which ascend the tract. The presence of pyogenic bacteria in the bladder causes an alkaline urine. The same is true with the pelvis of the kidney.

This brings us to a point of confusion because we may examine a specimen of urine passed in a normal way and find it acid in reaction. Still it has pus and bacteria, but let us remember that in case of infection it may be one side. The normal side excreting normal acid urine which counteracts the alkalinity from the infected side. A specimen may be obtained from each kidney separately collected by ureteral catheterization and tested.

Bacteria may ascend the tract or be carried by the blood to the kidney or reach the tract by continuity of tissue. Bacteria aid in the formation of stone because they cause pus mucus, fibrin and blood which acts as a cement for the crystals and form a nucleus for stone. Again stricture of the urethra such as scar tissue, enlarged prostate, or kink in the ureter which may cause an incomplete evacuation of urine leaving a sediment at some point will also aid in the formation of stone.

SUMMARY:

(1) Faulty metabolism.
(2) Premature precipitation of urinary salts, uric acid, ammonia urate, calcium oxalate, and phosphoric crystals.
(3) Bacteria.
(4) Stricture.

SYMPTOMS:

These vary as to the location of the stone.

Stone in the kidney substance or pelvis may not be recognized for a long time. The patient may only feel a slight backache, tenderness, no fever, and until at some time he may notice his urine is very cloudy, then have examination made. Even then it is easy for the physician to overlook the real trouble.

Stone in the ureter is different, and we are all very familiar with its symptoms. The same is true in bladder stone. Frequent urination from vesical tenesmus straining and dribbling urine, blood and pus. This may be easily recognized by passing a stone searcher or a sound, and you can feel the instrument top against the stone. Pain in pelvic and ureteral stone is reflexly transmitted to the external genetalia, and pain is severe.

DIAGNOSIS:

First: Stone in the kidney is the most difficult to diagnose, but we have some signs which give us a lead to work on. The patient complains of soreness in his back in the affected side. Tenderness when jarred. Blood is not always present in urine. There is often cast of pus. The case is chronic and pain moderate. Ureteral catheterization will show pus casts and sometimes blood from the affected side. X-ray for the stone.

Second: Stone in pelvis of kidney more often causes pain, sometimes blocking the mouth of ureter and giving symptom of hydro-nephrosis. There is tenderness over kidneys, pus and blood in urine, fever and nausea and vomiting when there is blocking of ureter. X-ray again comes to your aid. Pelvic stones may be as large as the pelvis of the kidney and may distend as it develops.

Third: Stone in ureter is fairly simple to diagnose because of the well-known pain. The direction of pain is downward, forward, towards the groins and testicles. Pain severe.

Fourth: Stone in bladder causes frequent urination, straining vesical tenesmus, blood and pus in urine, sometimes closing the urethra completely. The patient can pass his water better lying on his back.

A suspected stone in bladder which cannot be felt with a stone searcher can easily be seen through a cystoscope. Stone in the ureter will usually stop the passage of the catheter. This side will be blocked and no urine passed. The mouth of ureter is usually red and pouting. X-ray is nearly always employed to locate stone in any region except the bladder. There is though a chance to be misled by X-ray. That is where you have calcified glands along the ureter or around the kidney. This can be overcome by passing a lead catheter into the ureter or using a whalebone catheter with silver wire in it. This will show you the course of the ureter and its relation to the shadow.

TREATMENT:

Palliative.
Systemic.
Local and Surgical.

Palliative is very important and even though we may have gotten accustomed to giving hypodermic of morphine and hope for the passage of the stone by back pressure. Some teachers advise against morphine only as a relief until stone location can be made and further relief by operation. With me it is not always possible to get the patient to cooperate to this extent. So I believe morphine will have a tendency to relax the ureter and allow the passage of urine into the bladder, which is better than to leave the patient to suffer with its subsequent shock.

Elimination should be started from the bowels. Water freely with mild diet, patient warm or even hot pack.

Systemic treatment: This brings us back again to the condition of the blood. Is the alkalinity increased or reduced, gouty drathecis, rheumatism? Is the urine of normal constituency when liberated by the kidneys? As you probably have observed, patients may pass several stones in the course of one, two or three years. Having made a diagnosis of stone, I believe it our duty to try to find if it is what I have often wanted to call systemic or blood stone, not in structure, but in cause of stone having its sole origin in G. U. tract. That is if the blood was normal and the product eliminated was normal there would be no stone formation. We have many times examined urine and found it loaded with uric acid, calcium

oxylate, triple phosphate, calcium phosphate, hippuric acid, cystin crystals.

Some of these crystals accumulate in very acid urine, others alkaline or neutral urine. Calcium sulphate, which are rare, occur in very acid urine; calcium oxylate crystals occur in urine neutral slightly alkaline. Calcium carbonate crystals are formed in alkaline urine. I name the above conditions to impress the importance of the reaction of the urine, then try to ascertain the form of crystal present and you are in a fair position to correct the abnormality and reduce the danger of further stone formation.

Local treatment: Presence of pus and blood and bacteria aid in stone formation. Treatment is started by rendering the tract as sterile as possible. Pyelitis can be greatly improved by passing a ureteral catheter to the pelvis through which a solution of boric acid is injected and allowed to return. This may be followed with 1% silver nitrate solution. After 3 or 4 treatments other than T-B you get rapid reduction in the pus and usually the patient improves. Bladder irrigation with the ordinary solution where there is cystitis reduces frequency of urination.

Surgical: Stone in any portion of the tract should be removed. The method of removal will depend on the location of the stone, its size and condition of the patient. When in the kidney tissue it must be cut out. Pelvic stone may gravitate to the bladder if not too large. By X-ray its size can be determined and if more than one-fourth inches in diameter it should be removed and not allowed to pass through the ureter. Stone in ureter, even after it has started to descend, may add to its dimension and stop en route.

Stone in the bladder may be crushed or removed by suprapubic operation.

There are two important factors to keep in mind and when performing an operation for removal of the stone stay out of the peritoneal cavity if possible. Know the exact location of the stone. Before going into the kidney be sure of the other one's condition. Make a separate examination of the urine by ureteral catheterized specimen, and if there is any doubt a renal function test should be made.

While I served as interne in hospital I gathered all the renal stone I heard of that could be had, with the idea of studying their solubility in various chemical solutions or others. To my great disappointment I found that they would practically all dissolve in strong acid solution, but when I went to the weaker acid, etc., they were not all soluble. It was my hope to find some solution which by injection into the bladder, ureter or pelvis of kidney would dissolve the stone and at the same time not be injurious to the mucus tract. This is a point for study, and I believe will yet be worked out by some one with interest, knowledge, and means of study, which have not been my fortune to have. I will close by reporting two cases of interest to me and point to the mistakes made.

M. J. B., age 49. History of stone in right side four years ago. Passed same. Had malaria in 1924. Severe case. Urine at the time showed blood. Calcium oxylate. Uric acid crystals. Later, in 1925, had several attacks of renal colic in the opposite. X-ray showed no stone. Catheter passed to the kidney easily. Stone was later located in the pelvis of the kidney, by X-ray. Two weeks afterwards an operation was attempted to remove the stone from the pelvis of the kidney. To our surprise there was no stone in the pelvis, and none could be felt in the ureter as far as could be reached through the incision. In the two weeks' time between the X-ray findings and that of operation the stone had descended and could not be reached through the incision made. This points to the necessity of immediate operation after locating stone. Some months later he had severe renal colic. The stone was again located about two inches above the bladder. The stone was small and seemed as if it could be passed easily, therefore boric acid solution was injected into the ureter around the stone, for the purpose of sterilizing the area. Following this oil was injected around the stone with the hopes of lubricating it and aiding it to pass. Four days later the stone was passed into the bladder, but was still a very troublesome companion.

The bladder was filled with water and stone was washed to the beginning of the middle portion of the urethra and there it balked, having to be removed with a pair of crane bill forceps, while the patient was under ether.

Second case:

J. H., age 50 years; occupation, mechanic. Previous history negative. Had been able to follow his occupation almost daily. At intervals he would complain of soreness of back and occa-

(Continued on page 298)

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WOMAN'S AUXILIARY

The question has been asked as to what the work of the Woman's Auxiliary of the Florida Medical Association will be. There is much that this organization can do in furthering the interests of organized medicine in our state. The officers of the Association are looking forward to much assistance in the numerous phases of the Association work. Concisely summed up, the aims of the Auxiliary and the goals toward which it will work are as follows:

Through the wives of the doctors to extend the high aims of the medical profession to the various women's organizations which look to the advancement of health and preventive medicine;

To assist in entertainment of state, district and county meetings of the medical organization;

To promote acquaintanceship among the families of doctors that harmony and unity may be increased;

The placing of "Hygeia"—the magazine on preventive medicine published by the American Medical Association—in schools, libraries and other avenues to the public;

To assist in planting the ideal of child welfare and preventive medicine in the parents of today.

STATE NEWS ITEMS

Dr. J. C. Nowling of Ft. Myers recently announced that hereafter he will confine his practice to surgery and genito-urinary diseases.

* * *

Dr. Howard A. Kelly of Baltimore recently was the guest of the Pinellas County Medical Society and read a paper entitled "Emergency of Gynecology."

* * *

Dr. S. R. Norris of Jacksonville has removed his office from the St. James Building to the newly opened Wade Building, located at 1022 Park street.

* * *

Dr. A. J. Bertram of Hollywood will leave soon for Europe for a two months' trip. He will spend the major part of his time in Vienna, where he will study surgery.

* * *

The Pasco-Hernando-Citrus County Medical Society met with Dr. James F. Miller in Inverness, Tuesday evening, May 10th. Those present were Dr. George R. Creekmore, president, of Brooksville; Dr. George A. Dame, vice-president, of Inverness; Dr. T. F. Jackson, secretary, of Dade City; Dr. Porter J. Hudson of Crystal River; Dr. W. S. Hancock, Brooksville; Dr. J. L. Chalker, Ocala, councilor of the district of which Citrus County is a part; Dr. George G. MacGregor of Dade City and Dr. James F. Miller, Inverness.

After assembling at the offices of Dr. Dame, the physicians repaired to Johnston's Cafe and enjoyed a dinner as the guests of Dr. Miller. Following the dinner, the society was called to order and after routine business, a number of interesting case histories were reported and discussed. Dr. Chalker made an interesting talk on matters pertaining to the society and presented an invitation to become members of the Florida Midland Medical Society.

Dr. William N. Parkinson of St. Augustine was recently named as chief surgeon of the Florida East Coast Railway, succeeding Dr. J. N. Fogarty, who resigned.

* * *

The following resolution concerning the death of Dr. Robert L. Harris was spread upon the minutes of the Duval County Medical Society at their last monthly meeting:

"*Whereas,* on April 26, 1927, the Duval County Medical Society lost a valued member in the death of Dr. Robert L. Harris, and

"*Whereas,* Dr. Harris was one of the pioneer members of organized medicine in the state, a member of Orange County Board of Medical Examiners, prior to the organization of the State Board of Medical Examiners, and one of the members of the original State Board of Medical Examiners, loyal to his profession and active in its advancement and zealous in the welfare of his patients, and

"*Whereas,* his presence and valuable advice, the result of a knowledge gathered from years of experience, will be missed by his professional associates,

"*Be it resolved,* That the members of the Duval County Medical Society express their sorrow in the loss of Dr. Harris and sympathy for his family. That a copy of this resolution be spread upon the minutes of this society and a copy sent to his family."

* * *

Dr. Hewitt Johnston of Orlando sailed from New York June 8th for Vienna where he will spend several months attending clinics.

* * *

Drs. Ralph N. Greene and Ernest Milam have taken joint offices in the new Wade Building (Riverside Theatre building), Jacksonville.

* * *

At its regular meeting on May 10th, the Escambia County Medical Society had as its guests Dr. Abernathy of Flomaton, Alabama, and Dr. Hagood of Brewton, Alabama.

* * *

Members of the medical profession of Tampa who attended the American Medical Association meeting at Washington, D. C., were Drs. Earl McRae, M. R. Winton, J. B. Farrior, J. S. Helms, Sheldon Stringer, J. H. Mills, Rollin Jefferson, Geo. E. N. Hardy.

Dr. Howard A. Kelly of Baltimore, who is spending his vacation in Orlando, has presented Orange County with valuable property for a public park.

* * *

At the regular meeting of the Escambia County Medical Society held May 10th, a symposium on bronchial asthma was held. Dr. M. A. Lischkoff discussed bronchial asthma in its relation to rhinology. Dr. J. H. Fellows discussed bronchial asthma in infants and children; Dr. C. W. D'Alemberte discussed bronchial asthma in relation to indicanuria and the presence of histidin in the blood stream, due to fatty metabolism of proteins; Dr. H. L. Bryans discussed allergy in its relation to bronchial asthma; Dr. J. M. Hoffman discussed faulty calcium metabolism and ultra-violet irradiation in the treatment of bronchial asthma.

* * *

The Hillsboro County Medical Society held its annual picnic at Indian Rocks Beach on the 26th of May. The friends and families of the doctors swelled the attendance to about 250.

* * *

The Midland Medical Society met at Bradenton May 4th in an interesting one-day session.

* * *

Dr. E. T. Craney of Orlando recently left for Saiaval Lake to take special work in tuberculosis with Dr. Brown.

* * *

The June meeting of the Volusia County Medical Society will be devoted to a picnic at DeLeon Springs. The members and their families will enjoy a basket supper.

* * *

The Palm Beach Academy of Medicine was recently organized at West Palm Beach, and held its first regular bi-monthly meeting on May 11th.

The object of its organization is to promote the writing and reading of scientific papers, the reporting of interesting cases, and the liberal discussion of such papers and case reports.

Dr. W. E. Van Landingham, First Vice-President of the Florida Medical Association, was elected President; Dr. John E. Hall, Vice-President, and Dr. Lloyd J. Netto, Secretary-Treasurer. The Board of Governors elected were, Drs. J. F. Binkley, Berney S. Clay, Wm. J. Buck, V. D. Stone and F. Peter Herman.

Dr. Louis W. Toles was born in Eaton County, Michigan, January 6th, 1863. He attended grammar school, preparatory school and entered Rush Medical College, from which he graduated with honors. He engaged in general practice at Eaton Rapids, Michigan, later moving to Belleaire, Michigan, where he underwent many hardships in winter, never failing to respond to calls day or night in the face of snow and cold. The principal industry of this section being logging, there were many injured men to be taken care of and this gradually led Dr. Toles into general surgery. He later moved to Lansing, Michigan, where he was instrumental in erecting and equipping a large up-to-date hospital, and practiced with success until failing health forced him to take up special work. After extensive post-graduate work, he took up ear, nose and throat and plastic surgery.

He located in Orlando about two years ago and had many friends among the people of this section as well as the medical profession. He was taken seriously ill March 9th, 1927, and died May 11th, 1927, from uremic poisoning.

R. O. Cooley, *Necrologist.*

Dr. H. M. Cook, of Tampa, left June 5th for points in the East, and will conclude his visit by a few weeks' rest in Montreal, Canada.

* * *

Brig. Gen. Frank T. Hines, director of the Veterans' Bureau, has just been advised that everyone of the 52 hospitals maintained and operated by the Bureau has been fully approved by the American College of Surgeons which is the criterion in matters of this kind in the United States.

The Veterans' Bureau hospitalization program is the largest in the world, and attainment of this high standard throughout the service is one of the outstanding features of the present administration of the Veterans' Bureau.

Dr. H. C. Von Dahm, Medical Officer in charge of U. S. Veterans' Hospital No. 63, Lake City, and his staff, composed of Doctors Arnold, Black, Caldwell, Dyer, Gable, Hampton, Knox, Rogers and Welch, entertained the members of the Suwannee River Medical Society at their regular monthly staff meeting held at the Hospital on April 29, 1927.

The program was as follows:

5:00 p. m.—Informal inspection of hospital.

5:30 p. m.—Heart Clinic, Ward 3, Dr. Caldwell.

6:00 p. m.—Mess.

6:30 p. m.—Clinic—Nervous and Mental Diseases, Ward 1, Dr. Gable.

Clinic—Surgical, Ward 7, Dr. Dyer, Dr. Rogers.

7:15 p. m.—General Session, Talk, Dr. Welch.
Reception Ward Procedure, Dr. Hampton.

Presentation of Cases Showing Chest Pathology, Dr. Arnold.

X-Ray Plates, by Dr. Rogers.

Mechanical Aides in Heart Work, Dr. Caldwell.

Differential Diagnosis, Raynaud's and Endarteritis Obliterans, Dr. Dyer.

Those present were:

Doctors L. M. Anderson, T. S. Anderson, L. J. Arnold, R. A. Barnett, T. H. Bates, I. A. Black, Herbert Caldwell, D. E. Cline, Geo. Davis, J. D. Gable, R. B. Harkness, O. E. Hampton, Elinor Harthill, W. M. Ives, F. D. Knox, J. M. Price, A. E. Roberts, G. B. Smithson, H. M. Strickland, E. A. Welch, H. C. Von Dahm.

* * *

Drs. Gerry Holden and J. D. Pasco have removed their offices to the Wade Building, 1022 Park Street, Jacksonville.

* * *

On Friday evening, May 6th, the Dade County Medical Society held its regular meeting at the Floridian Hotel, at the invitation of the doctors of Miami Beach. Dr. Roche welcomed the society to Miami Beach and Dr. Cleghorn responded to his welcoming remarks.

After a delightful banquet, Dr. Woodard explained the fact that this banquet was being held in honor of Dr. J. A. Simmons. He called on Drs. Lyell, Claxton and Snyder for remarks of respect and honor to Dr. Simmons, and later Dr. Simmons thanked the members for this signal honor.

Dr. W. C. Jones read a paper on "Pelvic Infections," a most complete and thorough resume of the subject, both interesting and instructive.

KIDNEY AND BLADDER STONE

(*Continued from page 294*)

sional fever which was never very high. Usual diseases of childhood. About five years ago with one of these attacks I was called to see him. Back at that time was sore, slight fever, usual treatment was given, purgative and medicine for pain and diuretic. In a few days examination of the urine was made and found to contain pus and blood. Urine was very slightly acid. An examination of the bladder revealed practically no infection. Cystoscopic examination and a specimen of urine obtained from each kidney. The right side showed normal urine acid in reaction and free from pus or bacteria. The left side showed pus, blood and bacteria in large quantities. The urine very small in amount also contained casts of blood, pus and hylen. X-ray revealed a shadow in the pelvis of the kidney the size of a walnut. Operation was performed a few days later and a stone of large size was removed with the kidney. He has enjoyed fair health since that time and has been able to work practically all of the time since. The function of the other kidney has been normal. A mild diet has been recommended in order to relieve the kidney strain.

VOMITING IN PREGNANCY

(*Continued from page 291*)

them early, we must be definite in our instructions to them. To my mind, diet is one of the principal factors to take into consideration. Nourishment is recommended every two hours, and never less than four times a day. This should consist of solid food, rich in carbohydrates, as crackers, bread, bitter chocolate, raisins, dates, baked potatoes, stewed fruit, fresh vegetables, cereals, candy, and plenty of milk and water. The patient is instructed to keep something in her stomach practically all the time, and to eat once or twice during the night. The alimentary canal must be kept open. The choice of a laxative should be left to the patient. If she has none, I recommend Milk of Magnesia. Five grains of powdered whole ovary are given after meals; if not retained, the same dosage is given hypodermatically. One ampule of corpus luteum is given by hypodermic daily. If the nausea does not improve, give one ampule intravenously, morning and evening. If the patient is highly nervous and sleeps poorly, one

and one-half grains of luminol are given, morning and night. If the nausea increases to vomiting, and the vomiting to more than the once-a-day, or early morning type, the patient is removed to the hospital or isolated with an efficient nurse. Murphy drip is started, using eight to ten per cent glucose solution with five-tenths per cent sodium bicarbonate. This is given to capacity. If this fails, we prepare to give glucose solution intravenously by the technic of Victor J. Harding, who believes that as much or more depends on giving large quantities of water, as on the glucose given. "1000 cc. of 5% glucose solution in 1% saline is given intravenously each day, preferably 500 cc. morning and evening, until a diuresis is obtained, that is, when the twenty-four-hour output of urine reaches at least 1000 cc., with a specific gravity of 1.000, or less. Rectal enemata of 200 cc. of a 10% glucose in normal saline are given tid. At bedtime, thirty to sixty grains of sodium bromide are given in enema for the first day or so. Fluids are urged, even if the patient is vomiting freely, but no solids are given."

This treatment usually causes marked improvement within three or four days. The patient usually is able to take food at the end of that time. The treatment is not continued for a period longer than six days, but in the event of failure under these conditions, therapeutic abortion is performed.

The treatment of these severer types may thus be briefly described as rest in bed with isolation, forcing fluids by all routes. The use of glucose, though important, has become secondary to the use of fluids in treating a severe case of pernicious vomiting of pregnancy.

The precautions to be taken in giving this treatment are as follows: Never give more than 500 cc. of any fluid intravenously when you have a greatly weakened myocardium, as you sometimes have in this disease, unless the patient is markedly dehydrated. Be sure your glucose solution is pure. If it is pure you need not fear of a reaction, but it is not, a marked reaction will probably occur. Do not be afraid to induce an abortion when it is indicated, but remember that the indication is when the life of the mother is at stake.

REFERENCES

Victor J. Harding and N. B. Van Wyck, "The Use of Fluids in the Treatment of Hyperemesis Graviderum." American Journal of Ob. and Gyn., Jan., 1926. Philip J. Carter, "The Vomiting of Pregnancy, Its Causation and Treatment by Ovarian Extract." American Journal Ob. and Gyn., June, 1926.

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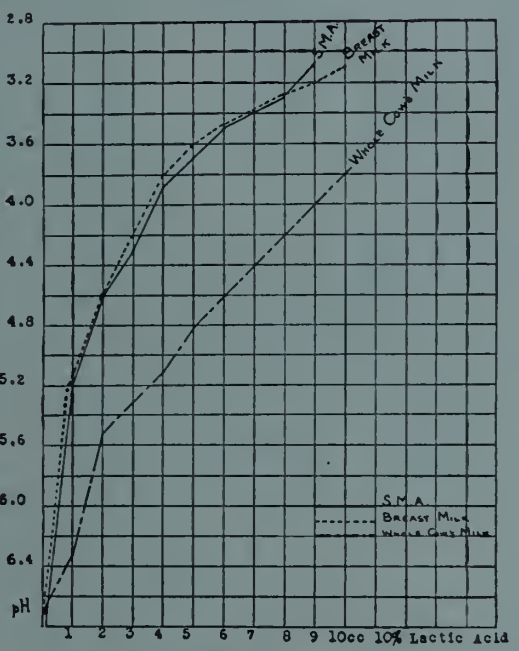
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WHY is it not necessary to add an acid to *S. M. A.*?

Answer

For the same reason that it is not necessary to add an acid to breast milk.

See chart



This chart shows the buffer curve of breast milk and cow's milk—and the similarity of the buffer curve of S. M. A. and breast milk.

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